DHMH 17 Rev 1/2001

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Cyrus Asadi)
31. Date filed (Month, Day, Year)

H0054424

20 E. Timonium Nd. #209 Timonium, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Day **Physician** Жм Zlizabett 2003 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Oakcrest Care Center Parkville Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 02-03-1922 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🛛 F Maryland Yrs. 214-20-9376 86 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 1 ☐ Yes 2 X No Directo Maryland Baltimore Parkville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 8820 Walther Blvd 21234 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: White 5-003 \$ 3 Widowed 4 ☐ Divorced 72 hours Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2121 filed within n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) traumatic event, the Own Home 8 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland æ Pages 1 and 2 should be Elizabeth (Unknown) John Paul Lobig ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Paul Joseph Lobig (Son) 1109 Bernadette Drive Forest Hill, MD 21050 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Oaklawn Cemetery 03-28-2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) permit. 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee Dans. noc Inc. 610 W. MacPhail Rd Bel Air, MD 21014 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Due to (or as a conse juence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months 1 Yes 2 No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown à signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 3 Probably 4 Donknown 1 Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy perform 1□ Yes **Division or Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA P this After thi 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. Certification: 1 Natural 5 ☐ Pending investigation Injury Vitin 24 hours after vol. 7 the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 8500 wilther Blon

State Registrar 31. Date filed (Month, Day, Year)

MAR 28

2008

DHMH 17 Rev 1/2001

00

0

N

32 Registrar's Signature

			4 101	artment of Health and Mental Hygiene rtificate of Death Reg. No. 2 1 1 8 1 1 1 1 3
			Decedent's Name (First, Middle, Last)	2. Date of Death 3. Time of Death
	Physici		Helen Lott Liberato	Month Day Year Mar. 24, 2008 12:15 P ^M
-	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death 4c. County of Death
-	LAdilli	iC:	St. Mary's Nursing Center	Leonardtown St. Mary's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign
	Director		232-26-6515 1□M 2⊠F 92 Yrs.	Months Days Hours Min. (Month, Day, Year) Country) New Jersey
	D		Usual Residence of Decedent	11/11/1525 101/10/15
	n the Maryland r 28a-f show	_	10a. State 10b. County 10c. City, Town or L	ocation 10d. Inside City Limits
	a-f s	당	MD St. Mary's Abell	1 ∆Yes 2 No
	可 or 28	Director	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?
	th wi	<u></u>	38687 Collinwood Dr.	20606 U.S.A.
	dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian,
9	after or it		1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No	4 Diversion National Control
9	72 hours after death with the Maryland natural", or items 23a or 28a-f show Mast Eventher I wat be notthed at	d by	3 ☑ Widowed 4 ☐ Divorced Year or Dates:	Specify: White
5-(72 h 'natu	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working 16b. Kind of Business/Industry
2	within ene. than "	ם	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)
2	al Hygie other t	ပိ		Homemaker Own Home
n c	G # D G	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
yla	ould Mer narke	မ	John Lott	Laura Giles
Maryland 21215-0036	ges 1 and 2 should be tt of Health and Mental If item 27 is marked or or other traumatic ev			ng Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	and lealth m 27 her t	0.3		7 Collinwood Dr., Abell, MD 20606
ore	Jes 1 Lof H If ite		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, cre	sition (Name of Date 20c. Location - City or Town, State natory or other place)
Ē	Z ii e a			shington Cem. 3/27/2008 Adelphi, MD
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other the once.			2. Name and Address of Facility 4739 Baltimore Ave.
<u>m</u>	9 Q F # 9		H Constance March Go	sch's Funeral Home, P.A. Hyattsville, MD 20781
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	
	Physician		Immediate Cause (Final	Onset and Death
	/Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	a carrina day
	Examiner		Deme	miles (UDA)
		Je.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of).	The state of the s
M	outed d ansit	Examiner	Tarly, leading to infriediate cause. Enter Underlying Cause (Disease or injury that initiated events	
0,0	an an rial-tr	EX	resulting in death) Last Due to (or as a consequence of):	
8760	cate be executed bhysician and the burial-transit	dical	d	
68	tifica ig ph as th	edi		
Box	eath certific attending p for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	23d. Date of delivery
œ.	deat e att	icia	1 Ves 2 No. 4 Pregnant at time of death 5	Sctopic pregnancy Other (specify) Month Day Year
P.0	t the by th ache	hys	9 Unknown	
Α,	iires that signed t d be deta		Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
Records,	quire an sig uld b	Completed by		1 ☐ Yes 2 █ No 3 ☐ Probably 4 ☐ Unknown
တ္တ	s bee	ete	SIP Bladder cancer A	The World William 24a. Was an 24b. Were autopsy findings available
Re	he la e ha	Ĕ	James Comment	autopsy performed? prior to completion of cause of death?
g	ificat or, pa	Č.	25. Was case referred to medical	1 □Yes 2 ♠No 1 □Yes 2 □No
>	sicla s cert irect	m	examiner?	26. Place of Death (Check only one)
Division of Vital	ding Physiclan: The In. After this certificate ha funeral director, page	Certification: To	1 Yes 2 No 1	4 Nursing Home 5 Hesidence 6 Other (Specify)
on	ding h. Afte fune	힐	1 Natural 5 ☐ Pending (Month, Day, Year) Injury 2 ☐ Accident investigation	28d. Injury at Work? M 1 □ Yes 2 □ No
S	Atten deat ctor: y the	lica	3 Suicide 6 Could not be 380 Place of Injury. At home form at	
Ö	after after Dire	ert	4 ☐ Homicide determined building, etc. (Specify)	City or Town, State)
	spita ours ieral filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat	n occurred at the time, date and place, and due to the cause(s) and manner as stated.
	Hos 24 h Fur etely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. Within 24 hours after death. Within 24 hours after death. Completely filled in by the funeral director, page 2 should be detached for use as	Me	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)
	- > F 0		busant bus The	D06419 3-15-08
		-	TOWNER TOWN ENTE	J 000 10 J 00 -00
	12		30. Name and address of person who completed cause of death (Item 23a) (Type,	
	,		31. Date filed (Month, Day Year) 32 Pristrar's Signature	Rd., Hollywood, MD 20636
	Stat Registra	-	31. Date filed (Month Day Year) MAR 2 8 2008 32. Signature	sact s

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Chadwick Lamont Mingia Certificate of Death 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day March 26, 2008 Medical Examiner 0536 hrs CHADWICK LAMONT MINGIA 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Capitol Heights Central Avenue & Garrett Morgan Boulevard 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Hours SEPT 20 1975 Country) NC Director 246 29 9507 32 1X M 2 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location PRINCE GEORGE'S DISTRICT HEIGHTS 1 X Yes 2 No MARYLAND 28a-f show the Maryland Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20747 2208 ODE STREET US with Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-14. Race - American Indian, Black If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces White, etc. 1XX Never Married death Yes 3 Widowed Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: BLACK <u>چ</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ 72 t. Pages I and 2 should be filed within 72 timent of Health and Mental Hygienerrant: If item 27 is marked other than "or other traumatic event, the Medical I the Medical MD 21215-0036 FORK LIFT DRIVER 12TH CANADA DRY 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SANDRA MINGIA LARRY DANIELS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SANDRA HARRIS / MOTHER 104 LOUISBURG ROAD SPRINGHOPE, NC 27882 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Itimore, tant: If its crematory or other place) 1 X Burial 2 Cremation 3 Removal from State permit. Pages Department of Important: I MEEKS CEMETERY SPRING HOPE, NC Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licenses MARSHALL'S FUNERAL HOME, INC. PMlushae 4217 9TH STREET NW WASHINGTON, DC 20011 Rad I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and lure. List only one cause on each line. /Medical a. Multiple Injuries Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. ne if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause Exami (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical UNPENDED AMENDED the attending physician led for use as the burial Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 V No 3 Probably 4 Unknown pleted peen page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? this certificate 1 🗸 Yes Yes 2 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: Other Nursing Home 5 DOA Residence 6 V Other: Scene ER/Outpatient 3 Inpatient 2 1 ✓ Yes No After the 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Certification: Mar 26, 2008 Pedestrian struck by auto 1 Natural 0511 hrs Yes 2 V No Director: d in by the f 5 Pending 2 🗸 Accident Investigation filled in by 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State)
Central Avenue & Garrett Morgan, Capitol Heights, MD determined (Specify) Local Street Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 26, 2008 30. Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAR

DHMH 17 Rev 1/2001 **OCME 2006**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 8,17 per fb 9878 4-1-08 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year March **Physician** 8.30A M 2008 SHANE McMILLAN MICHAEL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Randallstown Northwest Hospice Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day) year 1947 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours Oct. 24.1946 Maryland 218-48-9264 60 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Baltimore Ownings Mills Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21117 8600 McDonogh Road U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) McMillan Be Raymond Hershberger Eleanor Rinker ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victoria McMillan 8600 McDonogh Road Owings Mills, Maryland 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ICremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Green Mount Crematory 3-25-08 Baltimore, Maryland 22. Name and Address of Facility Mitchell-Wiedefeld F.H. Inc. 21. Signature of Funeral Service Licenses 6500 York Road Baltimore, Maryland 21212 23a. Parl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a disequence of): **Physician** End Huntingtons /Medical Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to forms a consequence off Examiner certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4□Pregnant at time of death 5 Other (specify) cate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? After this certificate has 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 27. Manyer of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural **Iniury** 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after dear To the Funeral Director 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospitai or 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

State

Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certified

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

25 Main Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

			_ 101	ıryland	d / Departmer	nt of H	ealth and N	Mental Hy	giene		
			1 - State Registrar		Certificat	te of L	Death		Reg. No.	2008	1000
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	eath Day	Year ^	3. Time of Death
	/Medic		Lenora M. Miller					MARC	H 2	7 2008	12:16 AM
	Examir	er	4a. Facility Name (If not institution, give street and number)				Location of Death	0	4c. 0	County of Death	٨
				DICAL		r 1 Year	GLEN 6	UKNIE	rth	HUNE	HRUNDEL
	Funeral Director		219-18-4346 1□M 2⋈F	83	Months		Hours Min.	8. Date of Bir (Month, Da Sept.	2 Year)	9. Birtin	place (State or Foreigr ntry) MD
	apte disco		Usual Residence of Decedent					осро.		747	TID
	ryfan how lat	_	10a. State 10b. County	10c. City,	, Town or Location						10d. Inside City Limits
	e Ma Ba-f s	cto	Maryland Anne Arundel			Pasa	dena				1 ☐ Yes 2 ☑ No
	vith th	Dire	10e. Street and Number		10f. Zip	p Code	04400		10g. Citiz	en of What Cour	ntry?
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notitled at	Funeral Director	185 Lake Shore Drive	Samuel II C	140 W Date	-14-610	21122			USA	an Indian
	ter de item ner n	ņ	11. Marital Status 1 □ Never Married 12. Was Decedent E Armed Forces? 1 □ Never Married 11. Was Decedent E Armed Forces? 1 □ Yes 2 □ N		If Yes, spe	ecify Cuba	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No Rican, etc.)	0- 1	 Race - Americ Black, White, 	
215-0036	irs aff	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:	0	1 ☐ Yes	2√ No	Specify:			Specify: Wh	nite
- 9	"natural",	ted	15. Decedent's Education		16a. Decedent's Usu	uai Occupa	ation		16b. Kin	d of Business/In	dustry
215	thin 7 e. an "n Medi	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5-	+)	(Give kind of wo life. DO NOT u	ork done d ise retired;	luring most of worl	king			
2	er th	S	10		S€	ecret	ary		Ma	nufactu	ring
nd L	ould be filed vould be filed vould be filed vounted other trafficerent, the	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	•	-	Surname)	
<u>~</u> ₩	should and Men s marke umatic	2	Albert J. Chapman				Una	Worle	<u> </u>		
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylar to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type. Print) Thomas J. Thompson (nephew)		19b. Mailing Address P.O. Box1						
	1 and Health em 27	_	20a. Method of Disposition	20b. Pla	ace of Disposition (Na	me of		Date		ation - City or To	
ການພະ Baltimore,	permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 Is marked other any Injury or other traumatic event, tt once.		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State	ce	metery, crematory or i n Haven Ce	other place	^{e)} ¦Anri			-	
· 🛓	nit. Partme		4 □ Donation 5 □ Other (Specify) 21. Signature of Euneral Service Licensee	Ture	22. Name a						Maryland
Ba	permit. Departr Importa any Inju		Much 10 Hald				untain R				Home, P.A.
			23a. Par 1. Enter the disease, if complications that caused shock, or heart failure. List only one cause on each lin-		o not enter the mod					a, MU Z	Approximate
	Physician		Immediate Cause (Final	1.00	do	Eas.	1. ~				Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a. Due to (or as a	consequ	ence of):	LOLL	ma				
- 18	Examiner		Sequentially list conditions h	DSI	9						
1	p #	iner	Sequentially list conditions, if any Louting to Instruction Cause. Enter Underlying Cause (Disease or injury	consequ	ence of):	-1					
n's	ecute and trans	Examiner	that initiated events	181	pertor	2/4					
, 90,	be excian a	<u>E</u>	Due to (or as a	consequ	ence of):						
68760,	icate be executed physician and s the burial-transit	edical	d CN	20	an cer						
	certifi ding se as		IF FEMALE: 23c. If yes, outcome p	of pregnan	ncv						
Box	eath certif attending for use as	cian	in the past 12 months?	2 Fetal	death 3 ☐ Ectopic p				2	3d. Date of delive Month	ery Day Year
P.O.	the d y the iched	Physician/M	1 ☐ Yes 2 TNo 4 ☐ Fregnant at 9 ☐ Unknown		0 0 0 0 0 0 0 0	poo.iiy)					
	w requires that the debeen signed by the should be detached	y P	Part II. Other significant conditions contributing to death bu	t not resul	ting in the underlying of	cause give	en in Part I.	23e. Did	tobacco us	e contribute to t	he cause of death?
r Sp	quire	ed by	Arral tibrilation	\triangle				10	Yes 2□]No 3□Prol	bably 4 Whknown
ဝ္ပ	law re as bee 2 sho	olete	Continuous on the					24a. Was		24b. Were auto	opsy findings available
Ä	The law requires that the death certif ate has been signed by the attending bage 2 should be detached for use a:	Completed	Grant & John State of the Company of	7					ormed?	death?	mpletion of cause of
ita	iysiclan: The lis certificate ha director, page	BeC	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only	21XINo one)	1 □ Yes	2100
> -	Attending Physician: r death. ector: After this certifice by the funeral director,	To E	1 Yes 2 No Hospital: 1 Inpatier	nt 2 🗆 E	R/Outpatient 3 D	OA Othe	r: 4 ☐ Nursing H	ome 5□Res	idence 6	□Other (Special	fy)
0 4	ding Phys n. After this funeral di	ü	27. Manner of De th 1 Natural 5 Pending 28a. Date of Injur (Month, Day	y Year)	28b. Time of Injury	28c. Injury Work	at ?	28d. Describe	how injury	occurred	
sio	tendleath.	cati	Accident investigation		M		res 2□No				
Division or Vital Records,	or At ifter d Direc in by	Certification:	4 Homicide determined 28e. Place of inju- building, etc	ry - At hor . <i>(Specify)</i>	ne, farm, street, factor)	ry, office		28f. Location (City or To	(Street and wn, State)	Number or Run	al Route Number,
_	To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Ö	29a. Certifier 1 Certifying Physician: To the best o	f my know	vledge, death occurred	at the tim	ne date and place	and due to the	Called(s)	and manner as	stated
	e Hos 24 h e Fur letely	Medical	(Check only one) 2 Medical Examiner: On the basis of and manner sta	examinati	ion and/or investigation	n, in my op	pinion, death occu	rred at the time	, date and	place, and due t	to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier		29	c. License	number		29d. Date	signed (Month,	Day, Year)
			1/2 Hamm III		(My	59910)	Mark	nh 2.	7th Trad
	12		30. Name and audress of person who completed cause of de	ath (Item	23a) (Type, Print),	1 1	<u> </u>		YMUN	A A	- auc
	/,		Julius C. Pham,	30	1 Hospita	11	1 60	1 Bur	NIP	MD	20161
9	Sta		31. Date filed (Month, Day, Year) MAR 2 8 2008	r's Signati	ure)	-			
	Registr	ar	WILL NO COULD STORES	S	Barreles						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month 740 PM David Mitchell 2008 March 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Belliam. Year If Under 24 Hrs If Under 1 8. Date of Birth (Month, Day, Aug. 11, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) New Jersey Sex 12M 2□F Months Days 75 Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Harford County Maryland Forest Hill 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2907 Kathleen Drive 21050 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ②Yes 2 □ No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White 3 ☐ Widowed 4 M Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Liquar Store Owner Sales 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) David Mitchell Mary Rankin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Panela Talley (Daughter) 2907 Kathleen Drive, Forest Hill, Maryland 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 [XCremation 3 ☐ Removal from State Evans Funeral Chapel Forest Hill, Maryland April 1,2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wins Funeral Chapel & Cremation Services — Bel Air 3 Newport Drive, Forest Hill, Maryland 21050 & COUR 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) lydeardir Due to (or as a consequence of): coronary Mean Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last MPars Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Might 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Anomia 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide

Examiner Pug death certificate be executed burial-transit Box 68760 ettending physicien as the t Į, ed by the P.O. Records, pege 2 should hes certificete of Vital ours efter death.

Nerel Director: After this certific filled in by the funeral director. Division

Physician

/Medical

Examiner

Director

ğ

Funeral

Director

77 is marked other than "naturel", or iteme 23a or 28a-f ehow traumatic event, the Mudical Exandrar must be notified at

it of Heelth and Mental Hygiene.

permit. Pages 1
Depertment of H
importent: if ite
eny injury or ott

Physician

/Medical

Examiner

Physician/Medical

ð

Completed

٩

Certification:

4 Homicide

(Check only one)

29a. Certifier

2 should be f and Mental h

Baltimore, Maryland 21215-0036

avid

To the Hospital or Attending within 24 hours efter death. To the Funerel Director: After completely

Medical

State Registrar

29c. License number

1 Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cauce(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

now Prent Ad

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 31. Date filed (Month, Day, Year)

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 1 State of Maryland (3) Population Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last)/ Lucille McLean 2. Date of Death Year **Physician** 2:30 AM 03 /Medical 4b, City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 1 AMAR AN 1M61 MOR If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day) Birthplace (State or Foreign Country) **Funeral** -32-225 1 ☐ M 2 👿 F Days Hours Director 4-14-1927 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at angle. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Baltimore Director 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21212 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian, 11. Marital Status Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced \act Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 13+2 Nursinx ltealth Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) h. Baltimore Thelma Baltimore MD 21212

20c. Location - City or Town, State Benninghaus Pod <u>876</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Porial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) Memoria 3.20.2008) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Vaushn C. Greene Fureral Services Vaughn C. Shame

4905 York Ind Baltimore M

23a. Partl. Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4905 York And Baltimore, MD 21212 Approximate Interval Between Opset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner OND Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last s a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions buting to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Be Completed 0 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No certificate has 2 No Hospital or Attending Physician: 25. Was case referred to medic examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2**∑** No 1 npatient ပ 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation (Month, Day) 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in 24 hours 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor **To the Fune** completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and add s of person R 2008 31. Date filed (Month, Day, Ye MAR 2 8 2. Registrar's Signatur State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month **Physician** ichae 2000 lleil awrence March /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Itimore Security Number 7. Age (In yrs, last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Mpnth, Day, Birthplace (State or Foreign Country) **Funeral** Year) Days 218-18-48 1 M 2□ F Months Hours Min. 26 Director BAUTIMORE MI Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. sther than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or Items 23a or 28a-f shovevent, il a livedical Evanifier must be notified at 1 □Yes 2 No Director HMORE 0 W501 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21286 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 1 1 Yes 2 No If Nes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify 2 Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) nd 2 should be filed wath and Mental Hygier 27 Is marked other the traumatic event, Its Maiden Surname 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Be) Tence ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health a.
Important: If Item 27 Is
any Injury or other trau 21286 100 Baltimore, 20a. Method of Disposition
1 Burial 2 Cremation 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 3
Removal from State 5 ☐ Other (Specify) 4 □ Donation 21. Signature of Funeral Service Licensee of Facility Timonium MD 21093 YORK RD. Simtelle -ALTERNATIVE SFUNERAL-CREMATION SPALCE 23a. Part . Enter the disease, or complication, that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** NG montas disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): physician s the burial Box 68760, Physician/Medical / the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) P.0. detached 9 Unknown 9 Unknown ò signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Hospital or Attending Physician: The certificate 2 🗆 No Division of Vital 1∐Yes 2∭N0 1 ☐ Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1∐Yes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier March 27 2008

State Registrar

DHMH 17 Rev 1/2001

megistral MA

31. Date filed (Month, Day, Year)

6701

MD

2. Registrar's Signature

N. Chances St

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** 1:40 PM MARIA MONALD March 2008 /Medical 4a. Facility Name (If not institution, give street and number Town, or Location of Death 4c. County of Death Examiner Baltinere N/A Midical If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 86 Days 1 □ M 2 🕱 F Director 213-30-7123 Italy 08-29-1921 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show "natural", or Items 23a or 28a-f shovedical Examiner must be notified at 1 XYes 2 No Directo Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 909 Trinity Street 21202 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No White Specify: þ 3 X Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within 7 ent of Health and Mental Hygiene.

1t: If item 27 is marked other than "n y or other traumatic event, the Medi Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important; If item 27 is marked any Injury or other traumatic ev Pietro Vidi Maria Ferrari 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Rosanna Biscotti - Daughter 137 Idlewild Road Severna Park, Maryland 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Xother (Specify) Entombment Parkwood Cemetery 03/29/2008 Parkville, Maryland 22. Name and Address of Facility 5305 Harford Road 21. Signature of Funeral Service Licensee Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Di acolan alsease **Physician** ons disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner cequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f Division or Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ξ Yes 2□No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an 1□ Yes 20 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2☐ No 2 ER/Outpatient 3 DOA 6 ☐Other (Specify) After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of c 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address

31. Date filed (Month, Day,

MAR 2 8

2008

law 18T. Baltinene 21201

f person who completed cause of death (Item 23a) (Type, Pint)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items 7,8 per fb 8877 3-28-08 vit
amend items 7,8 per fb 8877 3-28-08 vit
Black Indelible Ink. Ensure All Copies Are Legible.

For State Registrar

Amend Item 23c per me/dvr, 9867/06/19/08/49/ 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 930P M Marshall Tanl 03 25 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospital Baltimore Baltimore Specialty Iniversity If Under 1 Year | If Under 24 Hrs. Hours | Min. 8. Date of Birth 1926 (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 81 Yrs. 5. Social Security Number 6. Sex Funeral Hours Months Days 1 XM 2 ☐ F 215-22-1252 Sept.30, 1925 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State r 28a-f show notified at 1 ☐ Yes 2 XNo Directo Anne Arundel Maryland Jessup 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene.
Important: If hem 27 is marked other than "natural", or items 23a or: any Injury or other traumatic event, the Medical Examiner must be none. U.S.A. 20794 2053 Horseshoe Circle 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. MARSHALL, MAU 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 Specify چ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 N/A Contractor Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ **Ethel** Joseph <u>Marshall</u> Mary Triplet 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Grace M. Marshall (Wife) <u> 2053 Horseshoe Circle Jessup Maryland 20794</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 03/29/08 Loudon Park Cem. Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A.
3204 Mountain Road Pasadena, Maryland 21122 21. Signature of Funeral Service Licensee 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Sepsis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or John of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque fre Due to (or as a consequence of):

Head & neck injuried]s with comilications Physician/Medical Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician a IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown signed by t t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 1 Yes 2 No Aortic Value replacemen 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes → No Certification: To funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d Desartos how injury of curred SID Ject driver of 27. Manner of Death 28c. Injury at Work? After Natural 2 X Accident 5 Pending investigation with a truck thours are death.

*uneral Director: Af ely filled in by the full 1 ☐ Yes X ☐ No Jan 14, 2008 10:56 am ^M 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number ASBural Route Number City or Town, State) within 24 hours aller or To the Funeral Direc 4 Homicide Branch Rd. Glen Burnie, MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOU 61882 3-26-200X Mi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Charles St. Baltimere MD 21230 erdelia 31. Date filed (Month, Day, Year) gistrar's Signature State MAR 28 2008 Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend Item 25 per me, g877, 03/26/108 the of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year AM Marie February 21 2008 Nally 5:05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, of Location of Death 4c. County of Death Examiner 5. Social Security Number Baltmore n/a Medical etc Bayuren If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Min. 1 □ M 2√ F 79 Hours Dec 27 4 1928 Director 216-24-9416 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examples. 10a. State 10c. City, Town or Location 10b. Counfy 10d. Inside City Limits Baltimore MD n/a 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21224 228 South Robinson Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐**X**No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. þ White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own home Homemaker 18. Mother's Name (First, Middle, Maiden Surname)
Anna Mae Mackley 17. Father's Name (First, Middle, Last) Be Napfel Henry 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 228 S. Robinson St., Baltimore, MD 21224 Sandra L. Nally-daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Parkwood Cemetery 3/1/08 Parkville, MD 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee William G. Dau Home, 5305 Harford Rd., Baltimore, MD Funeral 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Bronchial obstruction with mucus plug disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Quality of the with weak maphragen was cough Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner CERTIFICATION APPROVEDES MEMCAL EXAMINER The law requires that the death certificate be executed Polymotor Newspathy attending physician and for use as the burial-tra Due to for as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Zijo No 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) February 27, 2008 Res - 000

Registrar

State

Harren Januier 31. Date filed (Month, Day, Year)

MAR 2 6 2008

Johns Liophins Baynew Medical Ctr, 4940 Easkin Ave, Balto, IND 21234

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician NORRIS 0230 A M III 2008 WILLIAM Η. MARCH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** THE JOHNS HOPKINS HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/18/1941 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5.**218**al**38**cu**5386**mber **Funeral** Months Days Hours Min. **1**M 2□ F 218 38 5836 66 WASHINGTON, DO Yrs Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County iral", or items 23a or 28a-f show Examiner must be notified at STEVENSVILLE 1 XYes 2 □ No Director QUEEN ANNES MD10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 106 GOLF COURT 21666 USA Funeral death Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after of the toth and Mental Hygiene.
ant: If Item 27 Is marked other than "natural"; or itel 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No altimore, Maryland 21215-0036 Specify: Specify: WHITE Completed by 3 ☐ Widowed 4 ☑ Divorced traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) ACCOUNTING ACCOUNTANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM H. NORRIS JR. JEAN CRAWFORD ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 Is any injury or other tra WILLIAM H. NORRIS IV(SON) 26 LONGCOURSE LN. PAOLI, PA. 19301. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State GREEN MOUNT CREMATORY 03/27/08 BALTO. CITY,MD. 4 □ Donation 5 □ Other (Specify) 21. Signature of Fuperal Service 22. Name and Address of Facility
HENRY W. JENKINS & SONS CO. 16924 YORK RD MONKTON, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ESOPHAGBAL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner and & attending physician and B The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy performed' death? 1**⊠** Yes 2 No 2 ☐ No or Attending Physician; 25. Was case referred to medical director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Certification: 1 Natural Injury s after dea. ral Director: Aftr 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral I

completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registra

DHMH 17 Rev 1/2001

State

h

31. Date filed (Month, Day, Year) MAR 2 8 2 2008



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

778CH Z4 Z0096

21287.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 12:32 A M aco 0 5/2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner N/A Sinai Hospital Baltimore 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** M 2 F 74 Director 219-30-3609 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Item 27 Is marked other than "natural", or Items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Baltimore Baltimore 1 ☐ Yes 2 🗗 No Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21229 6512 Banbury Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married White altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify Specify: 2 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Draftsman Koppers Inc 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be finance and Mental H Gunther Hilda Dorothy Geidt Nace Charles ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health an Important: If Item 27 Is n any Injury or other traur 2009 Halethorpe Rd., Halethorpe MD 21227 Ronald W. Nace (Brother) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Baltimore Crematory 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/28/08 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service License 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1 the the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to intrincialle cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-trans Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day P.O. I 5 Other (specify) ed by the detached 1 ☐ Yes 2 ☐ No 9 Unknown signed by d be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐ Yes 1∏ Yes Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes P☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Director: After Division Hospital or Attending Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the } and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

LIAQ

31. Date filed (Month, Day, Year)

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

821

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month MARCH 2008 12:11PM **Physician** VANDELIA T PETTUS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY TAKOMA PARK WASHINGTON ADVENTIST | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | APR 23 91 930 Birthplace (State or Foreign Country)
 A 7. Age (In yrs. last birthday) 52Social Security Number **Funeral** 1 □ M 2 🔀 F 77 Yrs Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location the Maryland 10b. County 10a State or 28e-f show treumatic event, the Medical Exactiner must be notified at 1 ☐Yes 2 ☐ No COVINGTON Completed by Funeral Director COVINGTON 10g. Citizen of What Country? 10f. Zip Code 24426 10a Street and Number 722 S. ALLEGHANY AVENUE permit. Pages 1 and 2 should be filed within 72 hours after death with 11 Department of Heelth and Mental Hygiene. Importent: if item 27 is marked other then "netural", or items 23a or 24 any injury or other treumatic event, Ite Medical Processing 1000. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) FLORIST floral designer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be VIOLA JAMES JOHN M. TRACY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DARLENE SMITH DAUGHTER 109 CHARTSEY STREET UPPER MARLBORO, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ALLEGHANY MEMORIAL PARK 3-22-08 COVINGTON, VA 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME 4217 9TH STREET, 20011 WASHINGTON, DC Marsh 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show or heart failure. List only one cayse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cerebrova Scular Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): ending physician a r use as the burial Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE. 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year atten for u Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ▼ No 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2♥ No ☐ Yes certificate 2 XNo o the Hospitel or Attending Physicien: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Umpatient P 1 ☐ Yes 2 ☐ Na 2 ER/Outpatient 3 DOA this After thi funeral 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner eath 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 1 Tatural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 03-16-08 MD 0060100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registar's Signature State MAR 2 8 2008 308133 Registrar

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registra 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Medical Examiner 1157 hrs March 22, 2008 Andrew Rayman 4a. Facility Name (if not institution, give street and number) c. County of Death 4b. City. Town, or Location of Death Upper Chesapeake Medical Center **Bel Air** Harford 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number If Under 1 Year If Under 24Hrs. **Funeral** 6 Sex 7. Age (In vrs. last birthday) Months Days Hours Director 38 12-01-1969 MD 219-78-3707 1 X M Country) 2 F Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Yes 2 X No 28a-f show Harford Bel Air MD notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21014 U.S.A. 413 Webster Street 23a with Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, must be r Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 2X No Yes Pages 1 and 2 should be filed within 72 hours after of trnent of Health and Mental Hygiene.
 Trant: If item 27 is marked other than "natural", o or other tranmatic event, the Medical Examiner. If Yes. Give Year Yes 2 X No specify: Widowed Divorce Specify: White \$ 16a. Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 Art Director Comic Distributor 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Lawrence Rayman Georgia Mullens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly A. Rayman (Wife) 413 Webster Street Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date Baltimore, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 03-25-2008 Baltimore, MD Bayview Crematory Donation 5 Other Specify 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Euneral Service Licenses MacPhail Rd Bel_Air, MD 610 W. Approximate Interval 23a. Part I. Enter the disease, in complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line 'Medical Death a. Hemopericardium Immediate Cause (Final disease xaminer or condition resulting in death) b. Ruptured Aortic Dissection Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine c. Hypertensive Cardiovascular Disease (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical ung physician a UNPENDED AMENDED The law requires that the death certificate be Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Day Live birth Fetal death 3 Ectopic pregnancy Month Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte I be detached for ι Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö 23e. Did tobacco use contribute to the cause of death? Þ Yes 2 No 3 Probably 4 ✔ Unknown Completed Records, plnods 24a Was an 24b. Were autopsy findings available has been autopsy prior to completion of cause of death? performed? this certificate ✓ Yes 2 1 V Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) funeral director, Division of Vital Be examiner' Hospital: 1 Other₄ Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 1 V Yes 28a. Date of Injury (Month, Dey, Year) 28d. Describe how injury occurred After 27 Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: 1 V Natural n 24 hours after death.

e Funeral Director; A etely filled in by the fu Yes 2 No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicid 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within To the 2 😿 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 23, 2008 30. Name and address of person who completed cause of death (Item 23a) Deputy Chief Medical Examiner Jack Titus MD. 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month Day Registrar's Signa State ear, 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3 Time of Death Month Vear **Physician** Walter F. Riehl 03 13 08 6:55 PM /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Locetion of Deeth 4c. County of Deeth Examiner Hospice Home Care of Memorial WMHS Cumberland, MDAllegany If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1 M 2□ F Months Days Hours 91 Director USA 214-05-8861 Usual Residence of Decedent 10a. Stete 10c, City, Town or Location 10b. County 10d. Inside City Limits Cumberland, MD 1 X Yes 2 □ No MD **Funeral Director** Allegany 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? USA 21502 13804 Bluejay Dr. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 K No Specify: Completed by Specify: Yeer or Detes: 143-46 3 Widowed 4 Divorced White 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 O Retired postal system 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Henry Riehl Edna Delilah Johnston 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Dorothy Riehl/spouse 13804 Blue Jay Drive SW Cumberland, MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from State 4XDonetion 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21. Signature of Funeral Service Ronald S. Wade Director Baltimore, MD 21201 23a. Pet 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Completed by Physician/Medical Examiner The law requires that the death certificeta be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last end Due to (or es e consequence of): of Vital Records, P.O. Box 68760, is certificete has been signed by the attending physicien director, page 2 should be detached for use es the burie Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was en autopsy performed? 1 🗆 Yes 2 No 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient Other: 4 \(\text{Nursing Home} \) \(\frac{1}{2} \) Residence \(6 \) \(\text{Other} \) (Specify) ٩ 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this funerel 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at 28d. Describe how injury occurred edical Certification: Aftar Division Hospital or Attending 5 Pending investigation 1 Quaturel deeth. seral Director: A 1 TYes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after d To the Funeral Direct complataly filled in by 4 Homicide 29a. Certifier certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner es stated.

| General Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner stated.

| General Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and tle of certifier 29c. License number 30. Name end addre who completed cause of deeth (Item 23a) (Type, Print) T.E. Williams, MD, 500 Memorial Avenue, Suite 301, Cumberland, MD 31. Dete filed (Month, Day, Year) 2. Registrer's Signeture State MAR 2 8 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1- For State of Maryland / Department	artment of Health and tificate of Death	d Mental Hygien	anno innia
		•	Registrar 1. Decadent's Name (First, Middle, Last)	mode or bodi.	2. Date of Death	3. Time of Death
	Physici		CHARLES KITTER		MARCIT 2	26 2000 730AM
)	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of De		c. County of Death
			1-UTURE CARE ChesAPRAKE	ARNOL	0	time trinool
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 12 N 2 F G Yrs.	If Under 1 Year If Under 24 H Months Days Hours M	lin. (Month, Day, Yea	
	Director		Usual Residence of Decedent		APA1 48, 17	138 Maryland
	how	_	10a. State 10b. County . 10c. City, Town or Lo			10d. Inside City Limits 1 ☐ Yes 2 No
	Ba-f	cto	Maryland Howard Sa	vage		
	with the or 2	直	100. Ströet and Number 8935 Baltimore Street	10f. Zip Code	10g. C	Citizen of What Country?
	vurs after death with the Marylan al', or Items 23a or 28a-f ehow Examination intilling	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13.1	20763 Was Decedent of Hispanic Origin?	(Specify Yes or No-	14. Race - American Indian,
9	or Iter	Fur	Armed Forces?	f Yes, specify Cuban, Mexican, Pu 1 □ Yes 2 No Specify:	uerto Rican, etc.)	Black, White, etc.
5-0036	within 72 hours after death with the Maryland ene. Then "hatural", or Items 23a or 28a-f ehow ha Madical Examinar naist ke inclitied at	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:			Specify: White
15-	"nati	Completed	(Specify only highest grade completed) (Give	tent's Usual Occupation kind of work done during most of i DO NOT use retired)		Kind of Business/Industry
2121	filed withi Hygiene. ther ther	ошб	Elementary/Secondary (0-12) College (1-4or 5+)	Carpenter		Contruction
	be filed tal Hygi d other event, I	BeC	17. Father's Name (First, Middle, Last)	18. Mother's N	Name (First, Middle, Maide	an Sumame)
Maryland	Men Men	To	Charles Ritter		atherine	(unknown)
Mar	12 sho h and 7 Is mu traum			ng Address (Street and Number or		y or Town, State, Zip Code) Jessup, MD 20794
_	os 1 end 2 of Health Item 27		20a Mathod of Disposition 20b. Place of Dispo	sition (Name of		Location - City or Town, State
ō	Pages nent of int: If it iry or o		1 Burgar 2 Cremation 3 Removal from State .	natory or other place) RIGHS Registry Mou	rch 26,2808 1	Hanover, MD
altimore,	permit. Pages Department of Important: If I eny Injury or once.	-	21. Signature of Funeral Service Licensee	. Name and Address of Facility	Anatomy Gif	
m .	88 5 8		Som Warker 7	522 Connelley	Drive Suit	P. Hanove MD 21076
			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cayse on each line			proximate Interval Between Onset and Death
	Physician		resulting in death)	VOCARDIAL	INFARCT	TON 3HOURS
	/Medical Examiner		Due to (or as a consequence of):			
	77	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
1	ecuted and I-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Cause (Disease or injury that initiated events C.			
90,		I Ex	resulting in death) Last Due to (or as a consequence of):			
98760		dical	d			
Box 6	leath certific ettending p	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
-	death e ette ed for	icla	in the past 12 months? 1 Vec 2 No. 4 Pregnant at time of death 5	Ectopic pregnancy Other (specify)		Month Day Year
P.O.	at the by th	hys	9 Unknown			
	The law requires that the death certifi ate has been signed by the ettending i age 2 should be detached for use as	by	Part fl. Other significant conditions contributing to death but not resulting in the u		23e. Did tobacc	2 No 3 Probably 4 Unknown
Ö	requi	eted	TSCHEMIC CARDIOMYUPA	(17)		
Records,	has law	Completed	SOIZUPE DISORDOR		24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
Vital		4	CHRONIC OBSTRUCTIVE PULN 25. Was case referred tomedical		Death (Check only one)	No 1 Yes 2 No
Ξ	Physician: r this certificatal director, I	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatier	Other	ng Home 5 ☐ Residence	6 □Other (Specify)
n of	ng Ph fter th ineral	on:	27. Manney of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 1 ☐ Natural 5 ☐ Pending	Work?	28d. Describe how in	ifury occurred
Sio	Attending in death. ector: After by the fune	cati	2 Accident investigation	M 1 Yes 2 No	COL Landing (Chant	And Number of Paris Day to Manager
Division	after a	Certification:	4 Homicide determined 28e. Place of Injury · At home, farm, stibulding, etc. (Specify)	eet, factory, office	City or Town, St	and Number or Rural Route Number, late)
	splta nours neral	aic	23s Canifier 1 Gentifying Physician: To the best of my knowledge, dans	h commed at the time, data and p	lane, and due to the cause	(a) and manner as storad
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi c,mpletely filled in by the funeral	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death o	occurred at the time, date a	and place, and due to the cause(s)
	1 1 2 2	Σ	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
•	1		1 mil 1 / Link 11.	V4603	60 100	aru 2+, 2008
			30. Name and add ess of person who implet cause of death (Item 23a) (Type,	erint)	nex Alixan	and 27,2008 SULLEMO 21/08
·	Sta	ate	31. Date filed (Month, Day, Year) Ø 32. Registrar's Signature	9.	17 - Juleto	WILLIAM PILO
	Regist	rar	MAR 2 8 2008	is 2		

08-02224	
Ronald Reed	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day March 20, 2008 1006 hrs RONALD WAYNE REED Medical Examiner 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Union Memorial Hospital **Baltimore** 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. **Funeral** Country 212-88-3461 Months Days Hours Director 42 01/22/1966 MARYLAND 1X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 X Yes 2 No 28a-f show MD N/A BALTIMORE CITY Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 808 ARGONNE DRIVE 21218 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. White etc. Armed Forces? 1 X Never Married 2 Married Yes Specify: BLACK Yes 2 X No specify: f Yes, Give Year Widowed Divorced 3 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12 yes I and 2 should be filed within of Health and Mental Hygiene.

If item 27 is marked other than DISABLED DISABLED 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ CHARLES REED JOYCE HEMMINGWAY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) JOYCE HEMMINGWAY-REED MOTHER 808 ARGONNE DRIVE, BALTIMORE MD 21218 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) 1 X Burial 2 Cremation 3 Pages 1 Removal from State KING MEMORIAL PARK 3/29/08 WINDSOR MILL, MD" Important: Donation 5 Other Specify: 21. Signa f Funeral Service Licens 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE., BALTIMORE, MD Enter to sease, or complications that caused the Approximate Interval ary Enter type sease, or complication allure. List may one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and /Medical Death a. Complications of Bacterial Endocarditis Immediate Cause (Final disease or condition resulting in death) **⊆**xaminer Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDED 23a, 27 per ME g878 4/10/08 amh X UNPENDED ending physician use as the burial requires that the death certificate be Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₽ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24b. Were autopsy findings available 24a, Was an prior to completion of cause of autopsy certificate has performed? death? ✓ Yes 2 ✓ Yes 2 No Hospital or Attending Physician: T 4 hours after death. Funeral Director: After this certifically filled in by the funeral director, p. 25. Was case referred to medical 26.Place of Death (Check only one Division of Vital Be examiner? Hospital: 1 Other 2 V ER/Outpatient DOA Nursing Home 5 Residence 6 Inpatient 1 Yes 2 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: 1 X Natural Yes 2 No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) determined the Hospital To the Funeral Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 7 Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within. and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number March 21, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

MAR 2

8

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 25,27,28a-f per me 9878 04/11/08dhb
Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Alie Lee Roberts MAR 26 23:35 PM 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HOSPITGI ST. AGNES If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, June 21 Birthplace (State or Foreign Country)

TIM 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** ^{Yea}r) 1931 Months Days Hours 1 □ M 2 🙀 F TN 219-32-3343 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show dical Examiner must be notifled at Baltimore Baltimore MD 1 ☐ Yes 2 X No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code s 1 and 2 should be filed within 72 hours after death with 1 Fleatht and Mental Hyglene. teath an "natural", or Items 23a or 2 other traumatic event, the Medical Examiner must be nother traumatic event, the Medical Examiner must be not 21229 USA 5615 Edmondson Avenue Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 X No Specify. Completed by 3 Widowed 4 □ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) homemaker domestic 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Patsy Gibson Alfred Mullins Let, Me.

Let, Me.

Department of Health and N.
Important: If item 27 any Injury or "" 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5615 Edmondson Ave., Baltimore, MD 21784 19a. Informant's Name/Relationship (Type. Print) Rankin Roberts Jr. (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Nourial 2 Cremation 3 Removal from State Crest Lawn Memorial 3-29-08 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Rome & Chapel Daige Hargest Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pseudomonas Wound 30975 Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner VENTRICULAR if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine 1s chamic attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) Ö ed by the a 9 Unknown ے signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been s Completed Chronic Kidney 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No page 2 s has autopsy perform certificate Division or Vital 25. Was case referred to medical examiner?
1 X Yes 2X No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ၉ this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Funeral Director: After completely filled in by the funera 03/17/2008 5 Pending investigation 12 Natural Accident Subject fell up three stairs. Unknown M 1 ☐ Yes 2 No death. 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5615 Edmondson Avenue, Baltimore, MD 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide determined within 24 hours after To the Funeral Dire ō **Home** To the Hospital ritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 19508 March 26, 2008. MD

State Registrar

AWAIS MASOD D MD

31. Date filed (Month, Day, Year)

MAR 2 8 2008

900 S 36 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CATONS AVE, Bastimore MD

OBERT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 26 AM 2008 /Medical 4c. County of Deatl 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner lriver sit and 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, 9. Birthplace (State or Foreign Country) War yland 7. Age (In yrs. last birthday, **Funeral** Hours Months Days 1 M 2 □ F Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 XYes 2 □ No Director more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code #102 death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 DUNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 212 No Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) ortant: If item 27 is marked other than "natulijury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1 Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be l and 2 should be fi lealth and Mental H ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (mother) #102 Department of Health a Important: If Item 27 is any Injury or other trai 20c. Location - City or Town, State Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State Zion Bahyland 22. Name and Address of Facility Sdowne, Md 4 Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses tue. 23a. Part1 The the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner anding physician and use as the burial-transit rema Turit The law requires that the death certificate be exec Due to (or as a consequence of): Physician/Medical attending p for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the s 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has all director, page 2 autopsy performed? Yes 2 No 1□ Yes To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 5 Residence 6 ☐Other (Specify) 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide 1 Lecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Box 68760, Division or Vital Records, P.O. To the Hospital or Attending Physician: within 24 hours a To the Funeral I

State

DHMH 17 Rev 1/2001

Registrar

29b. Signature and title of certified

1aVI

and manner stated

, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

18300

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 🛛 🦳 🦠 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 8:00 AM thur March ver 23, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore larleton Himore If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1 M 2□ F Months 92 220 03 670 Director Maryland Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene.

Is marked other than "natural" or thame 22 and 20 and 10 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 No Director altimore timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 2307 by Funeral 10 ane 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify. Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) employed Home Improvement or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be orae ٥ Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a Port Richer Beedon-daughter 8333 Fox Hollow Drive <u>ynthia</u> 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral Chapet of Cremation Syrs-Belair 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 Removal from State permit. Page Department o Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services - Parkuille
8800 Harford Road Parkville MD 21234 y lai 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ONGESTIVE /Medical Due to (or as a consequence of): **Examiner** DRONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 D Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manper of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

State

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) MAR 2 8 2008 Registrar

29b. Signature and title of certifie

EVANGE LOS

216NOS MD 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

7801 YORK Rd TOWSON, MD, 21204

		State of Maryland / Departm 1 - For State Amend item 23a, 25, 27, 28a - f per 1	nent of Health and ne. 8877,03/26, cate of Death	/08dhb	ne2008 002;
Physic /Medi	_	Decedent's Name (First, Middle, Last) LOIS S. SMITH		12 2	Day Year 3. Time of Death 22 2008 2 ISA M
Examin Funeral Director	ier	ANNE ARUNDEL MEDICAL CENTER 5. Social Security Number 6. Sex 1 □ M 2 ☒ F 7. Age (In yrs. last birthday) If L 160 01 3520 1 □ M 2 ☒ F 91 Yrs.	ANNA POLIS Inder 1 Year If Under 24 Hiths Days Hours Min	rs. 8. Date of Birth	4c. County of Death ANNE ARUNDEL 9. Birthplace (State or Foreign Country) PHILA, PA.
Maryland -f ehow	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD ANNE ARUNDEL ANNAPOLIS			10d. Inside City Limits 1 ☐ Yes 2 10 No
th with the 23a or 28a	Funeral Director	10e. Street and Number 6202 RIVERCRESENT DRIVE	f. Zip Code 21401		Citizen of What Country?
72 hours after death with the Maryland naturel; or iteme 23a or 28a-f ehow diest Examiriae must be notified at	by Funer	1 Never Married 2 Married 1 TYes 2 TXNo	Decedent of Hispanic Origin? specify Cuban, Mexican, Pures 2 No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE
ad within 72 hours aff giene. er then "naturel", or i, the Medical Exam	Completed	(Specify only highest grade completed) (Give kind of	Usual Occupation of work done during most of w OT use retired) KFD	vorking	AT HOME
nd 2 should be fited Ith and Mental Hygis 27 is marked other rtreumatic event, II	To Be Co	17. Father's Name (First, Middle, Last) JOHN THORN SCHELL	18. Mother's N	lame (First, Middle, Maid	den Sumame)
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel; or iteme 23a or 28a-1 show any injury or other treumatic event, the Medical Examiner must be notified at once.		MARILYN S.EVANS DAUGHTER 20a. Method of Disposition 1 Burial 2 ACremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 6 22. Nan	CO INC.	MILLERSVIL Date 20c 2/26/08 WE	LE, MD 21108 Location - City or Town, State
Physician /Medical Examiner		23a. Part. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	mode of dying, such as card	lac or respiratory arrest,	STER ST. BALTIMORE, Approximate Interval Between Onset and Death
ficate be executed physician and is the burial-transit	edical Examiner	di any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Cue to (or as a consequence of): Cue to (or as a consequence of): Due to (or as a consequence of):	CERTIFICATION NODROVED B	NINEDICAL EXPONENT	
death certii e attending id for use a	Physician/Me		pic pregnancy ar (specify)		23d. Date of delivery Month Day Year
sign d be	۵	Part II. Other significant conditions contributing to death but not resulting in the underly	ing cause given in Part I.	23e. Did tobace	co use contribute to the cause of death? 2 No 3 Probably 4 Unknown
The law ete hes b page 2 s	Completed	Bronchitis		24a. Was an autopsy performed	
To the Hospital or Attending Physicien: The law requires within 24 hours after death. To the Funerel Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be	Certification; To Be	25. Was case referred to medical examiner? 1 3 Yes 27. Manner of Death	ONA Other: 4 Nursing 28c. Injury at Work? 1 Yes 2 No	28f. Location (Stree City or Town, S	tripped and fell tand Number or Rural Route Number, State) 4000 River Cresce
To the Hospita within 24 hours To the Funerel completely filled	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurrence one) Medicel Examiner: On the basis of examination and/or investigender of manner stated.	irred at the time, date and pla	ice, and due to the causi ccurred at the time, date	e(s) and manner as stated. and place, and due to the cause(s) Date signed (Month, Day, Year)
7 × 5 × 6		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1065117	D := /:	2/22/08 Manica
<i>↑</i> Standard	ate rar	31. Date filed (Month, Day, Year) MAR 2. 6. 2008 A Park Way 32. Registrar's Signature	napolis M	0 2140	1 Saenz DO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Catherine R. Shortall 26, 2008 11:47 AMM March /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 719 Maiden Choice Lane HR424 Baltimore Catonsville 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 □ M 2√2 F Director 216-07-0059 Usual Residence of Decedent 91 07/04/1916 Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 21 No Director Baltimore Catonsville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 719 Maiden Choice Lane HR424 21228 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 Married "natural", or Maryland 21215-0036 1 ☐ Yes 2 No White Specify: 3X Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Proofreader Publishing t 2 should be filed w h and Mental Hygier 7 is marked other ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked c any injury or other traumation. Thomas Robinson ည Elizabeth Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1149 Oak View Drive Crownsville, Maryland 21032 Robin Meushaw - Niece Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Lakeview Cemetery 04/01/2008 Sykesville, Maryland 21. Signature of Funeral Service Livinse 22. Name and Address of Facility
David J. Weber Funeral Homes P.A. 5311 Edmondson Avenue Raltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ٥ mediate /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed burial-trans and Due to (or as a consequence of): attending physician Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Vear 4☐Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 TYes 2 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s certificate has autopsy death? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 217 No Hospital: 1 ☐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 ☐ Suicide 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Box 68760, P.O. Records, Division or Vital

To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After

State Registrar

29d. Date signed (Month, Day, Year)

\$202, Baltimore, MO 2,228

31. Date filed (Month, Day, Year) MAR 2 8 2008

(Check only one)

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 20 by Percent State of Marylands Teparither 1984 by the and Mental Hygiene 2 0 0 8 Amend Items 23a, 25, 27, 28a-f per inca \$877.03/26/08dhb 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FER B **Physician** MARIE REGINA SCHOTT 8:08 AM 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HOWARD COUNTY GENERAL HOSPITAL COLUMBIA HOWARD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan 23, 1916 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days 1 ☐ M 2 😾 F Hours 185-09-9481 92 Pennsylvania Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or dical Examiner must be 5400 Vantage Point Road; Apt #305 21044 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Yes 2 No <u>م</u> Specify Specify: White 3 Widowed 4 Divorced Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Macneill Florence Donohue 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Louis J. Schott Husband 5400 Vantage Point Road-Apt #305; Columbia, MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If i any injury or = 5 03/19/2008 4 Donation 5 Other (Specify) Arlington National Arlington, Virginia on National Arlington, Virginia
22. Name and Address of Facility Sterling Ashton Schwab Witzke 21. Signature of Fune al Service Livensee Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, M01290 Tart1. Enter to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ANOXIC ENCEPHALO PATHY DIPTIS /Medical Due to (or as a consequence of) Examiner MOITAIXYHASA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last MONTO BENTALISM EXPRIMENTAL TO THE PARTY OF Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical CERTIFIC IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 4☐Pregnant at time of death 9☐Unknown Month Year Day 5 ☐ Other (specify) been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPOTHYROIDISH GLAMCOMA VASCULAR NEMEDITA 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 A Natural 5 Pending investigation 02/06/2008 1 ☐ Yes 2 No Subject choked on bolus of 2 Accident Unknown after death Director: filled in by the 6 ☐ Could not be Location (Street and Number or Rural Route Number of City or Town, State) 5400 Vantage Point 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 0 Assisted Living Facility Road, Columbia, MD within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 038296 FEB 12, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOSEPH F. GIBBONS MD PIGG LARK BROWN RD, SMITE ZOI, ELICRIDGE, MD 21075 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

MAR 2 6 2008

Maryland 21215-0036

Baltimore,

Division or Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year :00 PM **Physician** lollen 2008 larie 21 nna March /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Parkville
If Under 1 Year | If Under 24 Hrs. North DOIG 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 M 2 ▼ F 218-36-0749 Hours 108 Nov 19, 1939 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

int: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ▼No Director arkvill MD altimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 91001 212 Completed by Funeral thwind 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bracken Plumbino 2 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Denning Hnna paers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9601 Northwind Road Angelo Tollen - Spouse

20a. Method of Disposition

1 Burial 2 Occemation 3 Removal from State Parkville mo 21234 20b. Place of Disposition (Name of cemetery, crematory or other place)

Exams Fineral Crapel

ECREMATION SV15- Belain Date 20c. Location - City or Town, State permit. Page Department o Important: If any Injury or 3/26/2008 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel + Cremation Services - Parkville Stac ~ 8800 Harford Road Parkville Maryland 21234 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Multiple

Due to (or as a consequence of): 3 years myelomo /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) sate has been signed by the page 2 should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed certificate 2 No 1□ Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 1 | Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural Injury 1 Yes 2 No within 24 hours after death.

To the Funeral Director: completely filled in by the f 2 Accident Could not be determined 3☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and itle of certif 29c. License number 29d, Date signed (Month, Dav. Year) D0033624 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 302 D 7505 OSIEr 32 Registrar's Signature Drive DWNS 31. Date filed (Mohth, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

MAR 28

2008

of DESAIMS

32. Registrar's Signature

Berew &

Maiden Charce lane catonsville

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

716

X DESTI (MD 31. Date filed (Month, Day, Year) D30494

3N5/2008

MD XIXLS

Registrar DHMH 17 Rev 1/2001

State

TRA

0 W

			1 - State Registrar	e of Maryland A	Depa <i>Cer</i>	tificate of E	ealth and M Death		jiene ()	08	10028
			Decedent's Name (First, Middle, Last)					2. Date of Dea Month	th Day	Year	3. Time of Death
12	Physici /Medi		Glen Clair Thrasher					3/23	/2008		10:27 am
	Examir		4a. Facility Name (If not institution, give street and	d number)		4b. City, Town, or	Location of Death			ty of Death	
12			Heartfields of Bowie 5. Social Security Number 6. Sex	7. Age (In yrs. last b	irth da)	Bowie If Under 1 Year	If Under 24 Hrs.	8. Date of Birth			orge's
	Funeral Director		513-01-2692 ^{1⊠M 2□}		Yrs.	Months Days	Hours Min.	(Month, Day 2/21/	Year)		lace (State or Foreign aska
	land land		Usual Residence of Decedent 10a. State 10b. County	10c. City, Tov	vn or Loc	cation				1	0d. Inside City Limits
	Mary -f eh	to	MD Prince George	's Chever	1v						1⊠Yes 2 No
	n 1he	Director	10e. Street and Number			10f. Zip Code			10g. Citizen o	f What Cour	ntry?
	th wit		2406 59th Place			20	0785		U.S	.A.	
	within 72 hours after death with the Maryland ene. then "naturel", or items 23s or 28e-f show its Medical Examinar must be notified at	Funeral	Arme	Decedent Ever in U.S. ed Forces?	13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Spi n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Ra BI	ace - Americ ack, White,	
36	, or i	by F	If Yes	/es 2 □ No s, Give	1	☐ Yes 2X No	Specify:		Spec	ify:	. .
Maryland 21215-0036	thur sture	ed	15. Decedent's Education	or Dates: WWII	ı. Deced	ent's Usual Occupa	tion		16b. Kind of	Whi Business/In	
215	hin 72	Completed	(Specify only highest grade comple	ted) ege (1-4or 5+)	(Give I	kind of work done di OO NOT use retired)	uring most of work	ing			,
2	giene giene er th	Com			eo1c	gist			Exp1o	ration	1
nd	d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name		Maiden Suma	am <i>e)</i>	
<u>Ş</u>	Men Men Marke Marke	မှု	Mort Thrasher				Maude Be				
ā	d 2 sh th and 7 ie n traun		19a. Informant's Name/Relationship (Type, Print)			g Address (Street a				n, State, Zip	Code)
بۇ	1 and Healt em 2		Margaret L. Thrasher, 1 20a. Method of Disposition	20b. Place of	of Dispos	59th Place sition (Name of		Date	20783 20c. Location	n - City or To	own, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "naturel", or Items 23a or 28e-f show any injury or other traumatic event. The Mudical Example intuities in notified at ADES.		1 Surial 2 ☐ Cremation 3 ☐ Removal 9 4 ☐ Donation 5 ☐ Other (Specify)	from State cemete	эгу, сгөл	atory or other place k Cemetery	4/3/2	0000			
를	ontine cortar		21. Signature of Fuperal Service Licensee	Withita		Name and Address		.000	Wichit 4739		Lmore Ave.
m	Per		H Constance	Jasen	Ga	sch's Fur	neral Hom	e, P.A.			Le, MD 2078
N. W. A.	Physician /Medical		23a. Part1. Enter the disease, or complications to shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	hat caused the death. Do on each line. Aspiration e to for as a consequence Dysphagia	Pne	, -	, such as cardiac o	or respiratory ari	rest,		Approximate Interval Between Onset and Death
,	icate be executed physician and the burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	e to (or as a consequence	of):						Many yrs
P.O. Box 68760,	The law requires that the death certificate be executed ale hes been signed by the attending physician and the page 2 should be detached for use as the burial-transit	Physician/Medicai	in the past 12 months?	s, outcome of pregnancy ive birth 2 Fetal deatl Pregnant at time of death Jnknown		Ectopic pregnancy Other (specify)				Date of delive	ery Day Year
	res the	٥	Part II. Other significant conditions contributing	to death but not resulting		2					ne cause of death?
ord	w require been sig should b	eted	11	7	,	000191	γ	1 1 4	es 2□No	3 Prot	abiy 4 Gonknown
Records,	The law cele hes b page 2 st	Completed	A-Yery Disease					24a. Was autop perfor 1 Yes	SV	 Were autoprior to co death? 1 Yes 	psy findings available impletion of cause of
Vita	sicien: Th certificate irector, pag	Be	25. Was case referred to medical examiner?				26. Place of Death				
<u></u>	Physi this c al dire	2	the same of the sa	1 Inpatient 2 ER/O			1: 4 Nursing Ho				y)
UC C	ding F	lon			Time of Injury	28c. Injury Work	at ? ′es 2 □ No	28d. Describe h	ow injury occ	urrea	
Division of	or Attending Ph ter death. frector: Atter th by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e.	Place of Injury - At home, foulding, etc. (Specify)	arm, stre			28f. Location (S City or Tow		n <i>ber</i> or Rura	al Route Number,
Ω.	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica		29a. Certifier Certifying Physician: T	to the best of my knowledg	je, death	occurred at the time	e, date and place,	and due to the o	cause(s) and place	manner as s	tated.
	the F the F Tplete	Medical	one) and	manner stated.				-,-			
	wit To	~	29b. Signature and title of centitier	over)ng M	1D	D 3/	1001		29d. Date sign	24/2	000
Ĺ	0+1	10	30. Name and address of person and completed Stuart T. Turkew		(Туре, І	Frint) 7500	Green n be 14	, MD	203	Dr. :	#430
100 Care	Sta Registi			32. Registrar's Signature		3					
DH	MH 17 Rev 1/2	001	4		-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #9 State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** march 22 0540 AM 08 /Medical Facility Name (If not institution, give 4b. City, Town, or Location of Death 4c. County of Death Examiner treet and number Medical Itimore More 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (tn yrs. tast birthday) Birthplace (State or Foreign Country), Funeral 100M 201F 213-54-8638 Director N.C. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at Baltimore 1 Yes 2 No Director Md 10e. Street and Number 10g. Citizen of What Country? by Funeral Was Decedent Ever in U.S. Armed Forces?

1 Pres 2 No 17 Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ■Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Social Securita CLERK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maigen Surname) Be Burnice 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto. Md. sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 5 ☐ Other (Specify) 21. Signature of Funeral Sovice Ucense BRUadway Part1. Enter the dishock, of heart fail isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, fure. List only one cause on each line. mmediate ause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of) /Medical Examiner Preumonie Sequentially list conditions, if any, leading to immediate cause. Liner Unicitying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) signed by the attending physician and of the detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Nonknown 1 TYes Completed peen: 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a, Was an has this certificate 1∐ Yes Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl or Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 TYes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred after death. Director: After 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral C Descritiging Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene St Bulhmore MD 2120 ema

State Registrar 31. Date filed (Month, Day, Year)

2. Registrar's Signature

	•	State of Maryland State of Maryland State Amend Items 23a,25,27,28a-	d / Department of Health -f per me 8877 03/2 -f per me 8877 03/2	and Mental Hyg 6 /08dhb	giene 008 1003			
Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last) E V V 4a. Facility Name (If not institution, give street and number)	Uhlig 4b. City, Town, or Location	2. Date of Deal Month of Death	Day Year 3. Time of Death O Z Z OO 8 11:25 P			
Funeral Director		5. Social Security Number 6. Sex 7. Age on yrs. 1. 1 M 2/2 F 95		nove 17 24 Hrs. 8. Date of Birth Min. Aug. 30	N/A N/A 9. Birthplace (State or Fore Country) Germany			
ō	tor	Usual Residence of Decedent 10a. State	y, Town or Location Baltimore		10d. Inside City Limit			
h with the	al Direc	10e. Street and Number 3320 Benson Avenue	10f. Zip Code		10g. Citizen of What Country? United States			
iges 1 and 2 should be filed within 72 hours after deeth with the Maryland at of Health and Mental Hygiene. If item 27 is trarked other than "natural", or items 23a or 28a-1 show or other traumatic event, it is Marucal Examinating must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Marned 3 Wildowed 4 Divorced 12. Was Decedent Ever in U.S Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	S. 13. Was Decedent of Hispanic O If Yes, specify Cuban, Mexica 1 Yes 2 No Specify		14. Race - American Indian, Black, White, etc. Specify: White			
d within 72 ho giene. or then "natur	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during mo life. DO NOT use retired) Homemaker	st of working	16b. Kind of Business/Industry Own Home			
should be filed ind Mental Hygi i marked other umatic event,	To Be C	17. Father's Name (First, Middle, Last) Max Voigt	1	ner's Name (First, Middle, riedrike Sch				
and 2 sho Balth and n 27 is m		19a. Informant's Name/Relationship (Type, Print) Willy Max Uhlig - Son	19b. Mailing Address (Street and Numb 1726 Selma Avenue	e, Halethorp	or, City or Town, State, Zip Code) De, MD 21227			
pernit. Pages 1 and Depertment of Health Important: if item 27 any njury or other tr once.	ı	Removal from State Mea	lace of Disposition (Name of edition Place) emorial Park 22. Name and Address of Faci	3-7-2008 lity Ambrose Fu	Elkridge, MD uneral Home, Inc.			
Physician /Medical Examiner	Physician/Medical Examiner	cal Examiner	Ical Examiner	238. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence cause). Due to (or as a consequence cause).	ementa Jence of): Auvexia	s cardiac or respiratory and		
The law requires that the death certificate ate has been signed by the attending physoage 2 should be detached for use as the		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes W No 9 Unknown Unknow	ncy death 3 Ectopic pregnancy		23d. Date of delivery Month Day Year			
quires that n signed b	۵	Part II. Other significant conditions contributing to death but not resu	ulting in the underlying cause given in Part		obacco use contribute to the cause of death? Yes 2 □ No 3 □ Probably 4 ☐ Unknow			
	e Completed	24a. Was an autopsy prior to death? Hyinty Hiroldism 25. Was as referred to medical 26. Place of Death (Check only one)						
hys his	on; To B				lence 6 Other (Specify) ow injury occurred			
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Certification:	2 Accident 3 Suicide 4 Homicide Outline investigation 6 Could not be determined 28e. Place of Injury - At ho building, etc. (Specify Nursing Home	28f Location (S	Multiple Falls 8f. Location (Street and Number of Rural Route Number, City or Town, State) 3320 Benson Ave.				
To the Hospital within 24 hours a To the Funeral Completely filled	edicai	29a. Certifier (Check only one) Certifying Physicien: To the best of my know 2 Medical Exeminer: On the basis of examinat and manner stated.	wledge, death occurred at the time, date a ion and/or investigation, in my opinion, de	and place, and due to the o	cause(s) and manner as stated			
To t Com	Σ	29b. Signature and title of certifier	29c. License number	- 0 · A	29d. Date signed (Month, Day, Year) March 03, 2008			
		30. Name and address of person who completed cause of death (Item Ming V / MM) 3320 Benson	Avenue, Bal	timore, 1	Maryland 2122			
Stat Registra		31. Date file (Month, Day, Year) 22. Registrar's Signat	Angelle i		,			

amend item 10h Ma Riand De877 3-28 08 arth and Mental Hygiene 1- State Registraramend #10b-f Per Inf G878 TUFF POS POST 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** LEWIS VARGA MARCH 26 2008 6:40AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner BALTIMORE** GILCHRIST CENTER TOWSON Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year)
Aug. 6.1922 7. Age (In yrs. last birthday) If Under If Under 24 Hrs. 5. Social Security Number **Funeral** Days Hours 1 □ M 2 □ F Months Yrs 216~38~2873 85 Aug._ Hungary Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County Harford County Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Eventian or unit by rotified at Harford 1 ☐ Yes 2 No Director Maryland Baltimore Balto Baltimore County Towson 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 531 Valley View 1333 Springvale Brive 21286 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black White, etc. 1 Tes X2(XNo If Yes, Give Year or Dates: 1 ☐ Never Married Ž Married White 1 ☐ Yes 2 🔀 No Specify Baltimore, Maryland 21215-0036 Specify 2 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'any injury or other traumatic event, the Meonse. Elementary/Secondary (0-12) College (1-4or 5+) 2 yrs Self~Employed Barber ll yrs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eszter Horvath Gyula Varqa 9 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1333 Springvale Drive Bel Air, Maryland 21015 Paula Nyitrai (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition

A ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3-28-08 Parkwood Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ²². Name and Address of Facility
Lassahn Funeral Home
7401 Belair Rd. Baltimore, Maryland 21. Signature of Funeral Service Licensee Zassakn 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final MONTHS **Physician** LUNI disease or condition resulting in death) /Medical Due to (or as a snsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and burial-tran Due to (or as a consequence of): ending physician use as the burial pe Physician/Medical IF FEMALE If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) P.O. s been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. of Vital Records, 至 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has b 1 ☐ Yes 2.40No certificate 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 Other: 4 Nursing Home 5 Residence 6 Dether (Specify) HOSACS 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation Division 1 Accident 1 ☐ Yes 2 ☐ No hours after death. Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MARCH 26. 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 NUMARCES ST, 84177 209 BALTIMORE, MA 21204 10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State

Registrar

DANIENE DOBERMAN,

MAR 2 8 2008

31. Date filed (Month, Day, Year)

Mo

32 egistrar's Signature

ORIGINAL

08-02372	
Aaron Williams	

aron Williams		State of Maryland / Department of Health and Mental Hy -For State Certificate of Death	aryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.						
Physicia Medical Examir	n/	Registrar 1. Decedent's Name (First, Middle, Last)	2. Date of Death	lav Year	3. Time of Death 2130 hrs				
edical Exami		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	March 25, 2	4c. County of Deat	h				
Funeral	4	1758 E. North Avenue Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.	8. Date of Birth		rthplace (State or				
Director		218-78-0643 1 XM 2 F 48 Yrs. Months Days Hours Min.	July 2	3,1959 Forei	gn puntry)				
япу		Usual Residence of Decedent 10a. State 10b. County , 10c. City, Town or Location			10d. Inside City Limits				
. §	٥	Md. N/A Baltimore	· · · · · · · · · · · · · · · · · · ·		1 Yes 2 No				
he Mary or 28a-	Director	10e. Street and Number 1750 F North Ave 21218	109	Citizen of What Cou	antry?				
eath with the Maryland items 23a or 28a-f sho ust be notified at once	$=$ \vdash	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp. 1 V Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto		14. Race - Ame White, etc.	rican Indian, Black,				
0036 within 72 hours after death with the Maryland piene. ter than "natural", or items 23a or 28a-f sh. Medical Examiner must be notified at once		1 Never Married 2 Married Armed Forces? I Yes 2 No No Specify: No Specify: No No Specify:		Specify: B	lack				
hours a	ted by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of w duning most of working life. DO NOT use retired to the control of t		l6b. Kind of Business	/Industry				
036 rithin 72 sne. rr than dedical	Completed	12 D Lahorer		Main-	tenance				
21215-0036 uld be filed within 72 hours a Mental Hygiene. marked other than "natura c event, the Medical Examin	Be Co	17. Father's Name (First, Middle, Last) LEV DV WILLIAMS 18. Mother's Name Anna	(First, Middle, Ma	aiden Surname)	Son				
	2	19a. Informant's N. e/Relationship (Type, Print) Sister 19b. Mailing Address (Street and Number or R	Rural Route Numb	er, City or Town, Stat					
nore, MD 2 ages 1 and 2 shou nt of Health and N t: If item 27 is r	ŀ	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	1	20c. Location - City of	m. M.d., 21206 or Town, State				
		1 N Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify:	2/2008	Lansde	owne, Md.				
Balti permit. Departir Imports injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 10 Seph 1	Funeral	Home, P. F.	1516				
Physician /Medical		23a. Part/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of fallage. List only one cause on each line.	r respiratory arres	t, shock, or heart	Approximate Interval Between Onset and Death				
xaminer	Ì	Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):			Death				
	<u>ه</u> ا	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):							
	Examiner	Cause: Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):							
be executed sician and urial - transit		d							
	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delive	ery				
ox 68760 eath certificate b e attending physi for use as the bu		23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify)	ancy	Month	Day Year				
Box he death c	hysi	1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e Did tob	acco use contribute (to the cause of death?				
P.O. Bres that the dailing signed by the be detached	þ	Part II. Other significant conditions Contributing to death but not resulting in the underlying cause given in 1 art i.		2 🗸 No 3 🗌 Pr					
ords, P.C w requires that as been signed?	Completed		24a. Was ar autops perform	y prior to	autopsy findings available ocompletion of cause of				
Vital Rec ysician: The la his certificate h	Com	25. Was case referred to medical 26.Place of Death (Check	1 ✓ Yes 2						
Vital tysician this cert	To Be	evaminer?		Residence 6 🗸 Oth	er: Scene				
Division of Vital Records, P.O. reformers that the sate retail. In Director: After this certificate has been signed by the funeral director, page 2 should be detended.		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	28d. Describe ho	ow injury occurred					
ivision or Atten after cleat Director:	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (St or Town, Sta		Rural Route Number, City				
Division Division Hospital or Attend 24 hour after death Funeral Directors stely fill d in by the		4 Homicide (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and	due to the cause	e(s) and manner as st	ated.				
Division of Vital Records, P.O. Box 6876C To the Hospiral or Attending Physician: The law requires that the death certificate within 24 hours after ceath. To the Funeral Director: After this certificate has been signed by the attending phys completely fill d in by the funeral director, page 2 should be detached for use as the b	Medical	one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.	at the time, date a	nd place, and due to	the cause(s)				
	Σ	29b. Signature and title of certifier 29c. License number O.C.M.E.		29d. Date signed (A March 26, 2008					
		30. Name and address of person who completed cause of death (Item 23a)	D 24204						
(<u>)</u>	ate	Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MI 31. Date filed (Month, Day, Year) 38. Registrar's Signature							
Regist	_	MAR 2 8 2908							

OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend State of Maryland / Department of Health and Mental Hygiene Tem 8 per fh, g882, 08/28/08dhb.

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day E.E., **Physician** MARCH Beatrice Carroll Wagner Ø1:45AM 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death Examiner Baltimore Center Towson If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours Min. 1 □ M 2 X F 0378571920 218-14-2917 88 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show at la or 28a-f shot be notified a 1 ☐ Yes 2X No Director Baltimore Glen Arm Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21057 United States items 23a 4200 Manorview Rd. must by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten idical Examiner Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No white Specify. Specify: 3 XWidowed 4 ☐ Divorced Year or Dates: Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, the M 12 homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eugene Schwoerer Carolyn Link 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glen Arm, MD 21057 Jennifer Wagner/daughter 4200 Manorview Rd. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State Garrison Veterans Cem. Mar. 31,2008 4 ☐ Donation 5 ☐ Other (Specify) Garrison, Maryland 22. Name and Address of Facility
Mitchell - Wiedefeld Funeral Home, Inc
Raltimore, MD 21212 21. Signature of Funeral Service Licensee 23a. Port1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** EXACERBATION OF CHRONIC OBSTRUCTIVE /Medical Due to (or as a consequence of): Examine PULMONARY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed and burial-tra Due to (or as a consequence of) P.O. Box 68760 attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown ō Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9☐Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, be 1 Yes 2 No 3 Probably 4 Unknown CONGESTIVE HEART FAILURE Completed DIABETES MELLITUS TYPE II 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 2 X No certificate 1□ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient P 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? I Director: After to in by the funera 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours af

To the Funeral D

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certification 29d. Date signed (Month, Day, Year) 208

Registrar DHMH 17 Rev 1/2001

State

DRIVE

OSLER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. D.

76/21 US 32 Registrar's Signature 7601

Robert Land

POH LIM.

31. Date filed (Month, Plays, Year) 2008

D37254

TOWSON, MARYLAND 21204

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month MARCH **Physician** Year ZZIZIS Land Amen 4:26 AM Louis F. Westphale /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Saint Joseph Medical Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours **™** M 2□ F 85 Director Md. 216-14-8263 2-1-1923 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show at 1 ☐ Yes 2 No notified Director Md. Balto. Co. Perry Hall 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code a or 4220 E. Joppa Road 21236 USA 23a must Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or items 11. Marital Status ?7 is marked other than "natural", or iten traumatic event, the Medical Examiner Black, White, etc. should be filed within 72 hours after and Mental Hygiene. In marked other than "natural", or iter 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 □ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Foreman Otis Elevator Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental H Be Louis Westphale Lena Schmidt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is rr any injury or other traum Ann Westphale Wife 4220 E. Joppa Road Perry Hall, Md. 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Dulaney Valley 3-28-2008 Timonium, Md. 21. Signature of Funeral Servige Ligensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) CORONARY ARTERY DISEASE /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): certificate be executed Exami physician and sthe burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical the attending for use as 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) 4□Pregnant at time of death Division or Vital Records, P.O. 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ANEMIA 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 : autopsy performed? 1∏ Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ XNo ို 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: or Attending 5 Pending investigation Injury 1 X Natural dea h. 1 □ Yes 2 □ No 2 Accident Director , 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral E the Hospital 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3-22-08 D 30263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOWSON, MARYLAND 21204 FRANCIS TAT: 31. Date filed (Month, Day, Year) KH00. M.D. OSLER DRIVE. 32. Registrar's Signature State 2008 Registrar

DHMH 17 Rev 1/2001

December Supplement Suppl			1	For State Registrar	State of Mar		partment e <i>rtificate</i>			Mental Hy	/gien Reg. N	A A A	0	1000		
## Settle William Procedure of December Section Sect	Dh		_		-,)						eath	6.00		Time of Death		
Director Direct	7		1			J) AmiN					26	200	8 1	2:55" ™		
Second processory Number 1	Exa	mine	r			Center	//	6 1		th	4	c. County of De	.110			
The state of the s	Fune	eral		5. Social Security Number 6. Sex	7. Age (Van	y) If Under	1 Year	If Under 24 Hrs	. (Month, D	ay, Yea	r)	Birthplace			
Employed Contractive Contrac	Mo tro	tor	-	025-12-0821	7 2. 8	33 Yrs.				07-30	-192	24		MA		
Employed Contractive Contrac	aryland show	, i		10a. State 10b. County	11	0c. City, Town or	Location									
Employed Contractive Contrac	the Ma 28a-f s	in the second	ec10			BALTIMO		Code			10a C	itizen of What				
Employed Contractive Contrac	3a or				STREET						rog. c		oodinity.			
Employed Contractive Contrac	r deat		nuera	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.			ispanic Origin? (an, Mexican, Pue	Specify Yes or N rto Rican, etc.)	0-			ndian,		
Employed Contractive Contrac	336 irs afte	DY I			1 MYYes 2 □ No If Yes, Give Year or Dates: 1 €	041-45	1 ☐ Yes 2	2 \ No	Specify:			Specify:	BLACI	K		
Employed Contractive Contrac	5-0C	To a		15. Decedent's Edu (Specify only highest grad	cation	16a. Dec	cedent's Usua	al Occup	ation during most of we	orkina	16b.	Kind of Busine	ss/Industi	ry		
TILLIAM WHITE 192, Informers hame (First, Middle, Lare) 193, Informers hame (First, Middle, Lare) 194, Informers hame (First, Middle, Mastern Burname) 194, Informers hame (First, Mastern Burna	121 within			Elementary/Secondary (0-12)						9	١,	NDV CTE	A NIT NI			
TILLIAM WHITE Same and Address (Signed and Number of Paral Roots Number, City or Torm, State, 2p Code) JOANN WHITE/WIFE Salo W. Lexinotron St., ATT. 10, Balt.To., MD 21201 200. Rece of Dissposition (Name of Code) Carried State of Code	il Hygie	, ,				DRIC	LLANII	NG E		me (First, Middle			HNIM	<u> </u>		
20. Large of of Disposation Control (Control (Co	# 2 to 5															
20. Large of of Disposation Control (Control (Co	Mar d2sh d2sh thand t7 ls m				· · · · · · · · · · · · · · · · · · ·		_									
Physician //Modical Examiner Physician //Modical Examiner //Modical Exa	= 00		-	20a. Method of Disposition		20b. Place of Dis	position (Nam	ne of								
Physician //Modical Examiner Physician //Modical Examiner //Modical Exa	Fage ment c ant: If				lemoval from State	GARRISO	N FORES	ST V	ET. 04-0							
Physician // Medical Examinor Program of the final failure. List only one cause on edch line. Program of the final failure. List only one cause on edch line. Program of the final failure. List only one cause on edch line. Program of the final failure. List only one cause on edch line. Program of the final failure. List only one cause on edch line. Program of the final failure. List only one cause on edch line. Program of the final failure. List only one cause on edch line. Program of the final failure. List only one cause on edch line. Program of the final failure. List only one cause on edch line. Program of the final failure. List only one cause on edch line. Program of the final failure. List only one cause on edch line. Program of the final failure. List only one cause on edch line. Program of the final failure. List only one cause on edch line. Program of the final failure. List only one cause on edch line. Program of the final failure. List only one cause on edch line. Program of the final failure. List only one cause on edch line. Program of the final failure. List only one cause on edch line. Program of the final failure. List only one cause on edch line. Program of the final failure. List only one cause of dealine. Program of the final failure. List only one cause of dealine. Program of the final failure. List only one cause of dealine. Program of the final failure. List only one cause of dealine. Program of the final failure. List only one cause on edch line. Program of the final failure. List only one cause on edch line. Program of the final failure. List only one cause on edch line. Program of the final failure. List only one cause of dealine. Program of the final failure. List only one cause of dealine. Program of the final failure. List only one cause of dealine. Program of the final failure. List only one cause of dealine. Program of the final failure. List only one cause of dealine. Program of the final failure. List only one cause of dealine. Program of the final	Balt permit. Depart Import	once.		21. Signs ture of Funeral Service License	y. Work	-on										
Physician / Medical Examiner The design in immediate cause in nature resulting in death) The part of				23a. Party. Enter the disease, or complishock, or heart failure. List only or	cations that caused the ne cause on each line.	e death. Do not e	nter the mode	e of dyir	ng, such as cardia	ac or respiratory	arrest,		Inte	erval Between		
Sequentially fet conditions: Sequentially fet conditions Due to (or as a consequence of):				disease or condition	- TNE	-	A									
The proposal of the part of th	The second second			_			Due to (or as a c	onsequence oi).								
Section The part	7 8 5			nause Enter Underlying	Due to (or as a c	onsequence of);							1			
Section The part	execution and al-tran		Xan	that initiated events							-					
FEMALE 20 Was decedent pregnant 1 We birth 2 Feetal death 4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery Month Day Year 1 Year 2 No 3 Probably 4 Ørinknown 2 2 No 4 Probably 4 Ørinknown 4 No 4 Probably 4 Ørinknown 4	376C tte be o				f											
State State	9 5 6	4 9		IF FEMALE:	2s. If was outcome of	programa										
1 Yes 2 No 3 Probably 4 20 No 3 Probably 4 20 No 3 Probably 4 20 No 1 Yes 2 No 3 Probably 4 20 No 1 Yes 2 No 1 Yes	Bo death o	9	Clair	in the past 12 months?	1 ☐ Live birth 2 [Fetal death			′					y Year		
1 Yes 2 No 3 Probably 4 20 inknown 24a. Was an autopsy performed? 1 Yes 2 No 3 Probably 4 20 inknown 24a. Was an autopsy performed? 1 Yes 2 No 3 Probably 4 20 inknown 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 3 Probably 4 20 inknown 24a. Was an autopsy performed? 1 Yes 2 No 3 Probably 4 20 inknown 24a. Was an autopsy performed? 1 Yes 2 No 3 Probably 4 20 inknown 24a. Was an autopsy performed? 1 Yes 2 No 3 Probably 4 20 inknown 24a. Was an autopsy performed? 1 Yes 2 No 3 Probably 4 20 inknown 24a. Was an autopsy performed? 1 Yes 2 No 3 Probably 4 20 inknown 24a. Was an autopsy performed? 25a. Place of Death (Check only one) 25a. Place of Death (Check only one) 25a. Place of Injury 26b. Time of Injury 26	at the by the trached	Physical Phy	ll ys	9 □ Unknown												
State	dS, I ires the signed	3	2	Part II. Other significant conditions cor	ntributing to death but r	ot resulting in the	underlying ca	ause giv	en in Part I.					_		
29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and didress of person who completed cause of death (Item 23a) (Type, Print) State 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name an Address of person who completed cause of death (Item 23a) (Type, Print) State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	w requested		elec													
29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and didress of person who completed cause of death (Item 23a) (Type, Print) State 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name an Address of person who completed cause of death (Item 23a) (Type, Print) State 31. Date filled (Month, Day, Year) 32. Registrar's Signature	The la		<u>.</u>							aut	opsy formed?	prior death	to comple 1?	etion of cause of		
29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and didress of person who completed cause of death (Item 23a) (Type, Print) State 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name an Address of person who completed cause of death (Item 23a) (Type, Print) State 31. Date filled (Month, Day, Year) 32. Registrar's Signature	/ital clan; ertifica ector, c	9		examiner?												
29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and didress of person who completed cause of death (Item 23a) (Type, Print) State 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name an Address of person who completed cause of death (Item 23a) (Type, Print) State 31. Date filled (Month, Day, Year) 32. Registrar's Signature	Or Or Physic rathis cral dire	F	2	I ☐ fes 2 ☑ No	1 Inpatient			/A	4 LI Nursing			<u>_</u>	pecify)			
29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and didress of person who completed cause of death (Item 23a) (Type, Print) State 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name an Address of person who completed cause of death (Item 23a) (Type, Print) State 31. Date filled (Month, Day, Year) 32. Registrar's Signature	nding off. T. After	1		1 ☐ Matural 5 ☐ Pending						Zod. Describe	, 110 W 111	ary occurred				
30. Name and oddress of person who completed cause of death (Item 23a) (Type, Print) State 31. Date filed (Month, Day, Year) 32 Registrar's Signature.	DIVIS II or Atte after des	ortific.		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office 28							28f. Location (Street and Number or Rural Route Number, City or Town, State)			oute Number,		
30. Name and oddress of person who completed cause of death (Item 23a) (Type, Print) State 31. Date filed (Month, Day, Year) 32 Registrar's Signature.	e Hospita 24 hours e Funera etely filler	O leading		(Check only 2 Medical Examin	ner: On the basis of ex	amination and/or	ath occurred a investigation,	at the tir , in my c	me, date and plac opinion, death occ	ce, and due to the	e cause e, date a	(s) and manner and place, and	as stated	d. e cause(s)		
State 31. Date filed (Month, Day, Year) 32 Registrar's Signature	To the within To the	Mo		29b. Signature and title of certifier								- '	-			
State 31. Date filed (Month, Day, Year) 33 Registrar's Signature				pr	MD			P	21195			3-26	- 2	008		
State 31. Date filed (Month, Day, Year) 33 Registrar's Signature	1					h (Item 23a) (Type	e, Print)	141	2 POONSE	Stroot	BA	Himo	R+ M	1/2/2/20/		
Registrar MAD 2 8 2008 Assessment American Ameri	- 6	State		31. Date filed (Month, Day, Year)	32 Registrar's	Signature	E DE	-111	N.C. CIO	J, R. O.		,	1.	- GUANT		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First_Middle_Last) 2. Date of Death H Year Day To Year ZVV **Physician** March BARBARA A. WENGER DVAM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore-Washington Medical Center Anne len Br m del Knin If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 □ M 2 😿 F 213-34-7762 Director 71 Nov 20. 1936 Virginia Usual Residence of Decedent a or 28a-f show be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Pasadena 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8256 Baltimore-Annapolis Blvd. 21122 Items 23a ciner must be USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s any injury or other traumatic event, the Medical Examiner must Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Midowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Board of Education Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Don A. Wilson Nellie V. Burwick ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry W. Wenger (Son) 8268 Waterford Road, Pasadena, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State Glen Haven Mem Pk 3/29/08 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ^{22, Name and Address of Facility} McCully-Polyniak Funeral Home, P 3204 Mountain Rd., Pasadena, Md. 21. Signature of Fune II Service Licensee Kevin E Ecker 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) eros **Physician** /Medical Due to ur as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery law requires that the death 3 Ectopic pregnancy ę in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) a□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 **N**O 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform After this certificate Vital 1□ Yes 1 ☐ Yes 2 1 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifies Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🐪 🕦 Certification: To 1 patient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division (Month, Day Year) 1'Aatural 5 ☐ Pending investigation Injury 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide TSCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and 29c. License number 29d. Data signed (Month, Day, Year)

State

Registrar

31. Date filed (Month, Day, MAR 2

DHMH 17 Rev 1/2001

o

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

Year)

2008

2008

State Registrar

within 7

2 WIL 29b. Signature and title of certified

30 Name and address of

person who completed cause of death (Item 23a) (Type, Print)

4

29d. Date/signed (Month, Day, Year)

Streat Wastrawster, 40 215

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 7:20P M March 11 2008 Allard Elizabeth May /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Charles Waldorf Waldorf Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 1, 1925 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex Funeral Months Days 1 □ M 2 🕁 F 82 578-22-8854 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Items 23a or 28a-f show ner must be notified at 1 TYes 2XT No Director Waldorf Charles Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20601 USA 4140 Old Washington Road and 2 should be filed within 72 hours after death vealth and Mental Hygiene. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married "natural", or 1 ☐ Yes 2x No Specify Specify: ģ White 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker of Health and Mental Hygie I Item 27 is marked other I r other traumatic event, th and Mental Hygin 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margie Davis Unknown 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28984 Shannon Ct., Mechanicsville, MD 20659 Arthur Allard/Son permit. Pages 1 a
Department of Hec
Important: If item
any Injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/16/2008 Charlotte Hall, MD Brinsfield-Echols 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License ²²BRINSFIELD ECHOLS FUNERAL HOME, P.A. - M00817 TIT 30195 THREE NOTCH ROAD, CHARLOTTE HALL, MD 20622 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. (ancer Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician Physician/Medical the th as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? /es 2 No 1∐ Yes e Hospital or Attending Physician: 7 24 hours after death. e Funeral Director: After this certifical 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 1 Natural (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No M 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Sulcide filled in by determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the I within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0061652 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Atul Katyal- 11350 Pembrooke Square Suite 304 Waldorf, Maryland 20603 32. Revistrar's Signature 31. Date filed (Month, Day, Year) State MAR 1 2008 Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple.

State of Maryland / Department of Health and Mental Hygiene U U O 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JOHN EDWARD BLOWE MARCH 13 2008 4:27 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner HARFORD MEMORIAL HOSPITAL HAVRE DE GRACE HARFORD 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Birthplace (State or Foreign Country) 1**∑**M 2□F Days Hours 229-48-0835 Yrs. Director 68 FEB 12, 1940 VIRGINIA Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MARYLAND HARFORD 1X Yes 2 ☐ No ABERDEEN Direct 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 502 PLAZA COURT, APT 1A 21001 USA by Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No BLACK Specify: Year or Dates: 1963-65 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BUS OPERATOR PUBLIC TRANSPORTATION 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JAMES EDWARD BLOWE VERA LEE TODD Baltimore, Man 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY ANN BLOWE / SPOUSE 502 PLAZA COURT, APT 1A, ABERDEEN, MARYLAND 21001 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.A. FERRIS & CO., INC 3/21/08 WEST CHESTER, PA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility LISA SCOTT FUNERAL HOME, P.A.
552 I EWIS STREET, HAVRE DE GRACE,
Do not enter the mode of dying, sugn as cardiac or respiratory arrest,)Cett-MD 21078 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Approximate Interval Between Interval and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physicien and s the burial-transit certificate be executed Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown 0 esulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 🗆 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes Division of Vital 1 Yes 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death
1 Vatural
2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No Director: / 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) l or A 4 | Homicide filled within 24 hours 6 To the Funeral C certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. D0036940 em 23a) (Type, Print) ALL COLONIA MANOR MA UNION AVENUE, HAVRE

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

rancine Brown	1- For State Certificat	nt of Health and Mental Hygiene e of Death	2008 1004 Reg. No.
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of	of Death 3. Time of Death
Medical Examine	Francine	Brown Month March	1 19, 2008
	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death Prince George's
	7312 Donnell Place #B5 5. Social Security Number	District Heights ay) If Under 1 Year If Under 24Hrs. 8. Date	of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign
Funeral Director			/21/1948 Maryland
	218-58-1359 1 M 2XF 59 Usual Residence of Decedent	Yrs. U 0	72171340 Haryrana
яну	10a. State 10b. County 10c. City, Town or	Location	10d. Inside City Limits
Aaryland 28a-f show 1 at once. ector	Maryland Prince Georges	Forestville	1 X Yes 2 No
the Maryland a or 28a-f sh tiffed at once	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
th the 13a or notifie		20747	USA
0036 within 72 hours after death with the Maryland jene. Irer than "natural", or items 23a or 28a-f she Medical Examiner must be notified at once ompleted by Funeral Director	1 V Nover Married 2 Married Armed Forces?	 Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, et 	
	1 Yes 2 A No	1 Yes 2 X No specify:	Specify: Black
ours aft	or Dates:	ecedent's Usual Occupation (Give kind of work done	16b. Kind of Business/Industry
5-0036 cd within 72 hours after tygiene. other than "natural", the Medical Examiner Completed by	Elementary/Secondary (0-12) College (1-4 or 5+)	ring most of working life. DO NOT use retired)	
within siene.	1 2 17. Father's Name (First, Middle, Last)	Homemaker 18.Mother's Name (First, M	Domestic
21215-0036 21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica To Be Comple		vis Frances	R Brown
2121; d Mental Is s marked tic event,	19a. Informant's Name/Relationship (Type, Print)	Mailing Address (Street and Number or Rural Rou	tte Number, City or Town, State, Zip Code 20743
MD d 2 sho lth and n 27 is aumati	Timothy Brooks/ Son 528		oitol Heights, Maryland
_ = 9 5 5		Disposition (Name of cemetery, Date y or other place)	20c. Location - City or Town, State
imo	4 Donation 5 Other Specify: Result	rrection 3/27/0	08 Clinton, Maryland
Baltimore, permit. Pages 1 a Department of He Important: If ite Important: If ite injury or other ti	21. Signature of Furieral Service Licensee	22. Name and Address of Facility Adams	Funeral Home PA
Physician	23a. Part I. Enter the disease, or combugations that caused the death. Do not	enter the mode of dying, such as cardiac or respiral	Aquasco, Maryland 20608 ory arrest, shock, or heart Approximate Interval
'Medical	failure. List only one cause on each line. Immediate Cause (Final disease a. Heratic steatosis		Between Onset and Death
_xaminer	Immediate Cause (Final disease or condition resulting in death) a. HETTLIC STEATOSIS Due to (or as a consequence of):		
<u>.</u>	Sequentially list conditions, if any leading to immediate b Due to (or as a consequence of):		
ted Insit	if any, leading to immediate cause. Enter Underlying Cause (Disease or many that imitated		
ssit set	events resulting in death) Last Due to (or as a consequence of):		
tO, e he executed ssician and burial - transit	X UNPENDED AMENDED 23a, 27 per ME	g878 4/9/08 amh	
60, ate be hysicia e buria	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
687 ertific ding p e as th	23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pregnancy	Month Day Year
). Box 68761 the death certificate by the attending phy ched for use as the Physician/M	4 Pregnant at time of death 5 1 Yes 2 ✓ No 9 Unknown g Unknown	Other (Specify)	- 0
m e feb é		in the underlying cause given in Part I. 236	e. Did tobacco use contribute to the cause of death?
, P.(1	Yes 2 No 3 Probably 4 Unknown
ords, w requir		24	a. Was an autopsy findings available prior to completion of cause of
Records, The law requires freate has been sig spage 2 should be		1	performed? death? Yes 2 No 1 Yes 2 No
Division of Vital Records, P.O. Ital or stending Physician: The law requires that the safter death. To Blorector: After this certificate has been signed by led in by the funeral director, page 2 should be detacled in by the funeral director.	25. Was case referred to medical	26.Place of Death (Check only one	
F Vit.	1 Yes 2 No 1 Inpatient 2 ER/OU	patient 3 DOA Other Nursing Home	5 Residence 6 Other; Scene
n of \ ding Phy After th funeral		ime of Injury 28c. Injury at Work? 28d. De	scribe now injury occurred
Sion Attend r death ector: by the	2 Accident Investigation 28e Place of Injury - At home, far		cation (Street and Number or Rural Route Number, City
Division ospital or Attending hours after death. Internal Director: After y filled in by the fune. Certification:	3 Suicide 6 Could not be determined (Specify)		Town, State)
e Hospi 24 hou e Funer letely fil		h occurred at the time, date and place, and due to t	he cause(s) and manner as stated.
To the He within 24 To the Fu complete!	one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.		
	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	YM. W	O.C.M.E.	March 20, 2008
	30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 11	1 Penn Street, Baltimore, MD 21201	
Stat	31. Date filed (Month, Day, Year) MAR 2 5 2008 MAR 2 5 2008		
Registra		CINAL	OCME
DHMH 17 Rev 1/2001	ORI	GINAL	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 14, Day 2008 Physician Mildred Ethe1 Burkman 10:20 pM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert County Nursing Center Calvert Prince Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2 🕅 F Hours 220-22-4669 81 Nov. 20, 1926 Washington, DC **Director** Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 XNo **Funeral Director** Calvert MD Prince Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Item 27 is marked other than "natural", or Items 23a or other traumatic event, the Medical Examiner must be 470 Dares Beach Road 20678 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If Item 27 is marked other the any Injury or other trainment. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Yes 27 No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: δ Specify: white 3 ☐ Widowed 4 🙀 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 waitress restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Alexander Marvin Stinnett Rhoda Limerick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leroy K. Burkman, son 3835 Westwoods Lane, Port Republic, MD 20676 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State All Saints Cemetery 03/19/2008 4 Donation 5 Other (Specify) Sunderland, MD 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licens 8325 Mt. Harmony Lane, Owings, MD 23a. Part1. Enter the disclase, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Pindisease or condition resulting in death) **Physician** <esponou /Medical Due to (or as a of nsequence of): Examiner Sequentially list conditions, if any, leading to infinitediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner attending physician and for use as the burial-trar Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Sevene 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performe 1□ Yes 25. Was case referred to medical examiner?
1 \(\text{Yes} \) No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home ပ 2 ER/Outpatient 3 DOA 1 Inpatient 5 ☐ Residence 6 ☐ Other (Specify) 27. Man r of eath 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred 1 × Natural

Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and fittle of certifier

Division or Vital Records, P.O. Box 68760,

State Registrar

2417 SOLOMONS ISI. Rd. M.D. LAhIRU OUSAT 31. Date filed (Month, Day, Year)

allmousa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra Signature

2008

D0027180

2008

Huntingtown Md. 20639

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien

ne	n	n	8		0	0		
No	U	U	0	8	100		- 1	

		State of Maryland /	Certificate of Death	Reg. No.	1008 1004	4			
	Physician	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Dey	3. Time of Dear				
-	/Medical	George Alfred Burroughs	4b. City, Town, or	March 11,	2008 2315 Pl	M			
أر	Examiner	4a Fecility Neme (If not institution, give street end number) 107 E. Huron Court	North Ea		Cecil				
	Funeral Director	5. Social Security Number 218–07–8797 6. Sex 1⊠ M 2□ F 88	Yrs. If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 08/30/1919	9. Birthplace (State or For Country) Maryland	reign			
	pue 🗼	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Tox	vn or Locetion		10d. Inside City Lir	mits			
	Meryl a-f sho		th East	1 ☐ Yes 2 ☒ No					
	uter death with the Merylen r terms 23e or 25e-f show inter must be notified at Funeral Director	10e. Street end Number 107 E. Huron Court	10f. Zip Code 21 901		izen of What Country? SA				
020	urs af	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1☒ Yes 2 □ No If Yes, Give Yeer or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuben, Mexican, Puerl 1 Yes 2X No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White				
5-0	"natural", ideal Ex	15. Decedent's Education 160 (Specify only highest grade completed)	e. Decedent's Usual Occupation (Give kind of work done during most of wo. life. DO NOT use retired)	rking 16b. K	ind of Business/Industry				
12	withir than	Elementary/Secondary (0-12) College (1-4or 5+)	Manager		etail				
pu	ニエキ こ か	17. Father's Neme (First, Middle, Last)		me (First, Middle, Maiden	Sumame)				
Za	should be fill and Mental H I marked oth umatic ever	George Francis Burroughs	-	Ann Green	To a Count To County				
<u>a</u>	475		b. Mailing Address (Street and Number or Ri 07 E. Huron Court, No						
Baltimore, Maryland 21215-0020	Pages 1 end in the second in t	1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Uni	of Disposition (Name of ery, crematory or other place)		ocation - City or Town, State ewark, DE				
Balti	permit. Pages I Depertment of H Important: If ite any Injury or ot pncs.	21. Signature of Funeral Service Licensee	ervices 22. Name and Address of Fecility Strano & Feeley 1 635 Churchmans Ro	Family Funer d, Newark, D	al Home E 19702				
		23a. Pert1. Enter the disease, or complications that caused the death. Do shock, or heart failure. Listonly one cause on each line.			Approximate Interval Between	ņ			
Mary St.	Physician /Medical Examiner		Coronary Artery	Di sease)	onset and Death				
	nlner	b			4				
ó	tificate be executed gphysician end es the bunel-trensit	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury							
68760,	ohysicii the bu	Cause (Disease or injury that initieted events Due to (or as a resulting in deeth) Last	consequence of):						
	anding suse es	d							
Box	death cer e ettendir ed for use siclan/A	Part II. Other significant conditions contributing to death but not resulting	in the underlying ceuse given in Part I.	23b. Did tobacco	use contribute to the cause of de	eath?			
P.0	net the death celd by the ettendir leteched for use	COPDIEmphysema, CVA	Dementia	1)⊠(Yes 2	□ No 3 □ Probably 4 □ Unk	known			
Division of Vital Records,	The law requires that the death certificate be executed site has been signed by the ettending physician end page 2 should be deteched for use as the buriel-trensit.			24a. Was an auto performed?	psy 24b. Were autopsy findir available prior to completion of cause of death?	-			
Re	te hes age 2			1 Ves 2	Y 1 ☐ Yes 2 No				
ital		25. Was case referred to medical examiner?		ath (Check only one)	and the second s				
on of V		1	Dutpatient 3	dome 5 Residence 28d. Describe how inju					
Division	or Attendent free deet freetor: in by the	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Plece of Injury - At home, building, etc. (Specify)		28f. Location (Street ar City or Town, Stete	nd Number or Rural Route Number, a)	,			
	within 24 hours e within 24 hours e To the Funeral D completely filled i	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge of the control of the basis of examination eand menner stated.	ge, death occurred at the time, date and place nd/or investigation, in my opinion, death occu	e, and due to the ceuse(s urred at the time, date and) and manner as stated. I place, and due to the cause(s)				
	withir To th	29b. Signature and title of certifier	29c. License number	29d. Da	ite signed (Month, Day, Yeer)				
		Mulhor & Modern MD	0005922	5 3/	12108				
	2+1VA	30. Name end eddress of person who completed cause of death (Item 23a MELCHOR E-MAPARANG, M.P. Zi	5 North Street Elk	ton MD ?	21921				
	State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	South !						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 24 MARCH 2008 5:19 рм MIRIAM Μ. BURRIS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Cecil Union Hospital Elkton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Young) June 26 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Months Days ^{Year)} 1923 Maryland 1 □ M 2 🔀 F Hours Min. 195-14-8018 84 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notifled at 1X Yes 2 □ No Director MD Cecil Cecilton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 136 East Main St. 21913 U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ᠫ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify ģ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Credit Manager Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be of Health and Mental | | Item 27 Is marked of | other traumatic eve Joseph C. Matthews Helen E. Husfelt ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph G. Burris (son) P.O. Box 326 Cecilton, MD. 21913 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If Ite any Injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Zion Cemetery 3/28/08 Cecilton, MD. 21. Signature of Eyneral Service Donnse Galena Funeral Home of Stephen L 118 West Cross St. Galena, MD. 2 L. Schaech 21635 M00510 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ailure. List only one cause on each line. Part1 Enter the shock, or heart Approximate Interval Between Immediate Caus inal disease or contion Exhinsive Physician disease or conflict resulting in death) /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed as the burial-tra Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Month Day 5 Other (specify) ed by the a detached f 9 Unknown certificate has been signed by ector, page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 1□ Yes 2☑1√No Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ₽ No 11 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the

State Registrar

VAMITA 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32 Registrar's Signature

Mili 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TULL

2008



UNION MOSPITAL

29c. License number

ELILTON MI

29d. Date signed (Month, Day, Year)

3/24/08

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 attending physician within 24 hours after death

To the Funeral Director;
completely filled in by the

Maryland

the

death v

Baltimore, Maryland 21215-0036

				24a	a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical			26. Place of	Death (Check	(only one)	
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other: 4 Nursi	ng Home 5	Residence	6 □Other (Specify)
27. Manner of Death 1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No		scribe how injur	y occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, fac fy)	ctory, office	28f. Loca City	d Number or Rural Route Number,)	
	nysician: To the best of my knowniner: On the basis of examin) and manner as stated. d place, and due to the cause(s)

29b. Signature and title of certifier Carolyn C. Houle M.D. 29c. License number D005/720

MARCH 241 2008

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CAROLYN C. HOVK M.D. JOHNS HOPKINS ATRIVERSIDE, 1321 RIVERSIDE PARKWAY

BELCAMP, MD 21017 31. Date filed (Month, Day, Year)

State Registrar

Medical

MAR 2 8 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🕦 🎧 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2008 Year March 10 **Physician** Elda Virginia Ba11 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Garrett Garrett Co. Memorial Hospital 0akland If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖫 F Yrs Director 234-72-3627 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f ehow other traumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 ANo St. George Director Tucker 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ŏ 26287 Rt1 Box 456 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married ŏ Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No à 3 ₩ Widowed 4 Divorced 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping Homemaker other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Peges 1 and 2 should be file Department of Heelth and Mental Hy Important: If Item 27 is marked other any niury or other traumatic event ORGS. Martha M. Davis Otis A. Shahan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Rt2 Box 167 Tunnelton, WV 26287 Luther Shahan 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Pifer Mountain Cemetery 4 ☐ Donation 5 ☐ Other (Specify) St. George, WV 21. Signature of Funeral Service Licensee 22. Name and Address of Facility David A. Burdock FH Oakland, MD Katherine D weiter 21 N. 2nd St. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 4 weeks Physician /Medical Examiner hypertrophic cardy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed the burial-transit physicien Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Inknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan autopsy performed Yes 2 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only only Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Appatient Certification: To 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 1 Natural 5 Pending To the noeppear within 24 hours after death.

To the Funeral Director: Alt 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one)

State Registrar

29b. Signatury and title of certifier

31. Date filed Month, Day, Year)

30. Name and address

of person who completed cause of death (Item 23a) (Type, Print)

1 4 2008

32. Registrar's Signature

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 12:10 P. March 09, 2008 Audrell Myrtle Bampton /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner South River Health and Rehab Center Edgewater Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days 1 ☐ M 2 🛛 F 96 Maryland 213-44-1660 August 19, 1911 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 XYes 2 □ No Director Anne Arundel Edgewater Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21037 U.S.A 144 Washington Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify. Completed by 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jacob Winters Isabella Ross ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 149 Duval Lane, Edgewater, Maryland, 21037 Susan Kidwell - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition March 11. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Important: It any Injury o **Cumberland Crematory** Cumberland, Maryland 2008 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. 21. Signature of Funeral Service Licensee 8 East Main Street, Lonaconing, Maryland, 21539 23a. Parri. Enter the disease, or or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slivick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) mahori Physician 12 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Examiner that the death certificate be executed sician and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2X No ed by the a 9∏Unknown 9 ☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed?
1□ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has certificate To the Hospital or Attending Physiclan: within 24 hours after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA P 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: After (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident **Director:** filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 385 March 10, 2008 cu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road, West River, MD Bicibaum 134 OWNSV. Jayre 31. Date filed (Month, Day, Year) 32, Registrar's Signature State MAR 1 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death

Medical To the Registrar

31. Date filed (Month, Day, Year)

MAR 1 2 2008

1. Decedent's Name (First, Middle, Last) 3. Time of Death March **Physician** 20ď8 Hazel Brooks 1:55P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 130 Hearne Rd. Apt 1014 Annapolis Anne Arundel 7. Age (In yrs. last birthday)
86 Yrs.

| Months | Days | Hours | Min. | Apr | 11 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗀 F 219-16-1713 Maryland 1921 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show notified at Mo Yes 2 No Maryland Anne Arundel Annapolis Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Me ical Examiner must be r 21401 130 Hearne Rd. Apt 1014 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: Black ≥ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry الله All Hygiene.

* All Hygiene.

* All Hygiene.

* All Hygiene. North Elementary/Secondary (0-12) College (1-4or 5+) 10th Nurse Assistant Arundel Hospital permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygic Important: If item 27 Is marked other if any Injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert D. Isaac Louise Griffin 19a. Informant's Name/Relationship (Type. Print) Step 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Butler (Daughter) 702 Glenwood St. Annapolis, Md. 21401 Baltimore, 20a. Method of Disposition Date 20c. Location - City or Town, State 20to Phase of Disposition (Name of cemeter), crematory drother place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State UM Church Cem 3-12-08 Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) 2WMme a RASA FA FAIII Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 Jarry B. Keese MOOY83 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** BESPIRATORY ACUTE DAY /Medical Due to (or as a consequence of): **Examiner** 6TASTATIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine requires that the death certificate be executed GLAPDER burial-tran and Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕰 No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9□Unknown 9 Unknown signed by tage Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown cate has been siç , page 2 should b Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has 1∐ Yes Division or Vital 2 N 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 □ Nursing Home 5 🗷 Residence 6 □ Other (Specify) 1 ☐ Yes 2 ☐ No P this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? ne Hospital or Attending P. n 24 hours after death. ne Funeral Director: After t 28d. Describe how injury occurred After Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 3/11/08 1447494 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KOREST PRIVE ANNAPOLIS, MP Moriand Y. LANGSTON, P.O. 1616

32. Pagistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2000 **Physician** 10:30 AM John Richard Bowles *larch* /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Burnie Glen Anne Arunde Baltimore Washington Medical Conter If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth **Funeral** Country, MD Months 1/25/1939 NYM 2 F 217-36-6590 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 Is marked other than "natural" or them. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Anne Arundel Gambrills MD 1 ∐Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21054 USA 950 November Ct. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 [25/es 2 □ No Vietnam If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2K☐ No Specify. à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Logistics Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eleanor Hall John Bowles 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
950 November CT. Gambrills, MD 21054 19a. Informant's Name/Relationship (Type. Print) Lorraine Bowles Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National 4/24/2008 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sorvice Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. Annapolis, MD 21401 12 Ridgely Ave. 23a. Part1. Enter the disease shock, or heart failure. e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PAN Creatic Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy perform 1 Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Nnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one)

Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, or Attending within 24 hours after death To the Funeral Director:

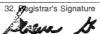
Registrar

HENry

31. Date filed (Month, Day, Year) MAR 1 3 2008

PANCIS

29b. Signature and title of contifier



Baltimore

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Washington Medical Center

29d. Date signed (Month, Day, Year)

March 8, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Marylan					lental Hyg	jienę	000	10010
			- State Registrar		Ce	rtifica	e of Dea	th		ag. No	UUÖ	10049
	Physici	an	Decedent's Name (First, Middle, Last)	_					Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al	Lillian Marie Loui			4h Cin	Taura and anothin	an of Dooth	March		008 County of Deat	10:52 P M
7	Examin	er	4a. Facility Name (If not institution, give s Anne Arundel Medic				Town, or Location				nne Aru	
700	Funeral		5. Social Security Number 6. Sex		last birthday)	If Unde	nnapolis	der 24 Hrs.	8. Date of Birth (Month, Day			hplace (State or Foreign untry)
3	Director		001-05-1641	M 21XF 91	Yrs.	Months	Days Hou	rs Min.	5/16/1	916	New	Hampshire
	pu s		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation						10d. Inside City Limits
	/anyla	ō	Maryland Anne Aru		Arno1							1 ☐ Yes 2 🗓 No
	28a-	Director	10e. Street and Number			10f. Zi	p Code			10g. Citiz	en of What Co	untry?
	h with		1211 Farley Ct.			2	1012			US	A	
	ma i	Funerai	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Dece	dent of Hispanic ecify Cuban, Mex	Origin? (Spitican, Puerto	ecify Yes or No- Rican, etc.)	1	4. Race - Ame Black, Whit	
36	within 72 hours atter death with the Maryland ene. than "netural", or itema 23a or 28a-f show f.a Medical Exemblear most be notified at	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 🕅 No If Yes, Give	1	1 🗆 Yes					Specify:	171-24-
8	tural'	ed b	3 X Widowed 4 □ Divorced 15. Decedent's Educ	Year or Dates:	16a, Dece	dent's Usu	ial Occupation			16b. Kin	d of Business/	White
15	n n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of w	ork done during r use retired)	most of work	ing			,
212	giene grene er tha	mo:	6th	College (1-401 54)	Fac	ctory	Worker			T	extile	
nd	ba file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)				18. M		e (First, Middle,		Sumame)	
Уa	Men	To	Omer Desroc				10		lia Demo		T O	7-0-4-1
Mar	d 2 sh th and 7 Is m traum		19a. Informant's Name/Relationship (Ty) Guilferd O. Boisve			-	s <i>(Street and Nu</i> ley Ct.,					zip Code)
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or itema 23a or 28a-f show any injury or other traumatic avent, It a Medical Examinatorial be notified at adds.		20a. Method of Disposition	20b. F	Place of Dispo	osition (Na	me of		Date		ation - City or	Town, State
OL.	Pagas ant of nt: If i		1 ☐ Burial 2 ☐ Cremation 3 XIR 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Toon Box	•	Cemeterv	3/12	/08	۸11،	netown	NH
E E	mit. F partmy sortar / injui	1 4	21. Signature of Funeral Service License		2:	2. Name a	nd Address of Fa	acility Ge	orge P.	Kala	as Fune	ral Home
m	F 0 F 0		Wallant Ville	ch								MD 21037
			23a. Part 1. Enter the disease, or compli shock, or heart failure. List only or							rest,		Approximate Interval Between Onset and Death
1	Physician		Immediate Cause (Final disease or condition	Due to (or as a consec	trac7	+ in	faction	1/50	Insis			Onsot and South
	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):				•			
Fa'	48.51	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec	quence of):							
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									
ó	te be executed ysicien and e burial-transit		resulting in death) Last	Due to (or as a consec	quence of):							
8760,	2 2	licai										
x 68	Attending Physician: The lew requires that the death certifica rideath. sctor: After this certificate has been signed by the attending phy the funeral director, page 2 should be deteched for use as the	Physician/Med	IF FEMALE:	3c. If yes, outcome of pregn.	2004						0.1 0.11.1.	
.O. Box	attend for us	sian	in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of c	al death 3	⊒Ectopic ; ⊒ Other (s	oregnancy			2	3d. Date of de Month	Day Year
o.	the d	ysk	1 ☐ Yes 275 No 9 ☐ Unknown	9□Unknown			poony)					
Division of Vital Records, P.	s that nad b	by Pł	Part II. Other significant conditions con	tributing to death but not res	sulting in the u	underlying	cause given in P	art I.	23e. Did to	bacco u	se contribute to	the cause of death?
ğ	equire en sig ould b	ed t	dial-+-) Neumoni-					1 🗆 Y	es 2	No 3□P	robably 4 Unknown
eco	lew re as be 2 sho	piet	'						24a. Was		24b. Were a	utopsy findings available comptetion of cause of
<u></u>	The rate h	Completed							perfor 1 ☐ Yes	med? 2 No	death?	2 □ No
<u>K</u>	ician: certific ector,	Be	25. Was case referred to medical examiner?	lospital:			Othor		h (Check only o			
of	Physical direction	2	1 Yes 25 No.	1 Inpatient 2 28a. Date of Injury	ER/Outpatie			Nursing Ho	ome 5 ☐ Resid			ecify)
on	ding th. After fune	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	м	28c. Injury at Work? 1 ☐ Yes	2 🗆 No		,		
Visi	Atten r dea ector	ifica	3 Suicide 6 Could not be determined	28e. Place of Injury - At h	iome, farm, st	reet, facto	ry, office		28f. Location (5 City or Tox			ural Route Number,
Ó	s afte	Certification:	4 Homicide	building, etc. (Speci	·y/				City of You	m, State)		
	To the Hospitel or Attending Physician: The les within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	(Check only 2 Medical Examin	sician: To the best of my known or on the basis of examination	owledge, deat ation and/or in	th occurre	d at the time, daten, in my opinion,	e and place, death occur	and due to the red at the time,	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)
	o the ithin 2 o tha omplei	Med	one) 29b. Signature and title of certifier	and manner stated)	2	c. License numb	ber		29d. Date	signed (Mon	th, Day, Year)
2	⊬ ≯ F 8		V Cle w	1 Im,)		D418	716		3/	10/2	008
18. .	ha	Kl	Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type,	, Print)	-10	20 1	R			
	Ma	7	Charles W. Phal	M MD 1350	10 50 lu	mons,	Lsland K	d. H	napolis	M	219	0/
1	Sta Registr		Name and address of person who concluded the second	32. Figistrar's Sign	ature.	bout	E)					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 23a per dr., g879.05/30/08dhb Reg. No. 1 - For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year **Physician** RUSSELL COPULOS MARCHI 2008 MILTON /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** MEDICAL CENTER BURNIE ANNE ARONDEL GLEN BALTIMORE WASHINGTON Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Months 264-92-5678 1**X** M 2 □ F Yrs. 60 Aug. 20, 1947 Director Illinois Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show an "natural", or items 23a or 28a-f shov Medical Examiner must be notified at MD Crofton 1√TYes 2 No Anne Arundel Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1620 Eton Way 21114 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1966— 15 Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White ò 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Marian of the management of the management of the Marian of th (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Consultant Energy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Aristedes Copulos Barbara Walsh ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Copulos / Wife 1620 Eton Way Crofton, MD 21114 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 3/20/2008 1 Burial 2 □ Cremation 3 □ Removal from State Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Arlington Nat. Cemet. 21. Signature of Funeral Service Licensee. 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** SEPTI'C /Medical Due to (or as a consequence of): Examiner AJULI RESPIRATORY if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed Crohn's Disease Due to (or as a consequence of): attending physician for use as the haria Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached t 9□Unknown 9 ☐ Unknown signed by be detail 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tyes 2 No 3 Probably 4 Hunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 10 Yes 2 No e Hospital or Attending Physiclan: 24 hours after death. 9 Funeral Director: After this certifica funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 10 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Wedical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. the 29c. License number 29b. Signature and title of certifies 29d. Date signed (Month, Day, Year)

3+1

State Registrar

DHMH 17 Rev 1/2001

MOSPITA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TSION

WASHINGTON

32. Registar's Signature

BACTIMORE

MAR 1 4 2008

31. Date filed (Month, Day, Year)

10053

-703

21060

BERHANE

Records, P.O. Box 68760 Division or Vital To the Hospital or Attending Physician: e Funeral Direc the

Registrar

Medical

29a, Certifier

(Check only

46B Thomas

32. Registrar's Signature 31. Date filed (Month, Day,

29b. Signature and title of certifier GAZIMD

and manner stated

30. Name and address of person who completed cause of death-(Item 23a) (Type, Print). 46B Thomas Buson Drum, Frederich MD 21702, AZI+ECAZI, ws

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D 44164

29d. Date signed (Month, Day, Year)

08-02148			pe or Print in B					gible.		
Myrlande Charle	_	ne St I- For State	ate of Maryland		nt of Health ar te of Death	nd Mental Hy	ygiene	4	2008	1005
Physicia	ın/	Registrar 1. Decedent's Name (First, Midd	le,Last)				Date of Deat Month	Dav	Year 3.	Time of Death
Medical Exami		Myrlande 4a. Facility Name (if not institution	on, give street and number		orlemagne 4b. City, Town, c	or Location of Death	March 16,	2008 4c. Cour	nty of Death	1919 hrs
		Laurel Regional Hosp			Laurel	- Inches in the control of the contr	To Day (Die		e George's	lace (State of Farcian
Funeral Director		5. Social Security Number 189-70-1873	6. Sex 7. A	ge (In yrs. last birtho	Months Da		-	11,195	Count	
w any	ŀ	Usual Residence of Decedent 10a. State Maryland Prince	e George's	10c. City, Town of Beltsvi						Od. Inside City Limits Yes 2 No
hours after death with the Maryland natural", or items 23a or 28a-f show Examiner must be notified at once.	향	10e. Street and Number 5116 Caverly P.			10f. Zip Code 2070	5	11	Og. Citizen of Haiti	What Country	
death with the ritems 23a	Funeral I	11. Marital Status 1 Never Married 2 X M	12. Was Deceder Armed Forces 1 Yes			an, Mexican, Puerto	pecify Yes or No Rican, etc.)		/hite, etc.	n Indian, Black,
s after	by F		vorced If Yes, Give Year	maleted) [16e D	1 Yes 2 N		work done	Spec	ify: BI	ack
nore, MD 21215-0036 ages I and should be filed within 72 hours after nt of Health and Mental Hygiene. nt: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner.	Completed by	15. Decedent's Education (Spe Elementary/Secondary (2-12)		dı	uring most of working li tified Nur	fe. DO NOT use reti	ired)	Medi		usiry
215-0(be filed wi ntal Hygien ked other ent, the M	Be Cor	17. Father's Name (First, Middle Roger Sajous	e, Last)			18.Mother's Name Yvana Je			ame)	
MD 21 12 should 1 th and Mer 1.27 is mar umatic ev	2	19a. Informant's Name/Relations Pierre Charlema		d 51	Mailing Address (Str. 16 Caverly	Place Be		e, Mai	yland	20705
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hou Department of Health and Memtal Hygiene Important: If item 27 is marked other than "nat injury or other traumatic event, the Medical Exa		20a. Method of Disposition 1 Burial 2 X Crematio 4 Donation 5 Other S	-	cremator	Disposition (Name of cry or other place) colitan Cre		Date /24/2008	1	on-City or To	
Baltil permit. Departm Importa		21. Signature of Funeral Service		4	22 Name and Address 4400 Powd	sseffacilly Borgward er Mill F	dt Funer Road Bel	al Hon	ne, PA le, Mar	yland20705
Physician /Medical		23a. Part I. Enter the disease, or failure. List only one cause	e on each line.		enter the mode of dyin	g, such as cardiac o	or respiratory arr	est, shock, o	r heart	Approximate Interval Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a con		5e					
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated	Due to (or as a con	sequence of):						
cecuted 1 and - transit	cal Exar	events resulting in death) Last	Due to (or as a con			-/				·
O, be exe sician a	edic	XUNPENDED			r ME g878 4/2	8/08 amh 		- 35		
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be exhibit 24 hours after death. After this certificate has been signed by the attending physician upletely filled in by the funeral director, page 2 should be detached for use as the burial	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in t past 12 months? 1 Yes 2 No 9 ✔ Un	the 1 Live birth 4 Pregnant	ome of pregnancy 2 at time of death 5		B Ectopic pregna	ancy	23d. Da	te of delivery th Da	y Year
D. B. t the de by the		Part II. Other significant condi	a Clikilowii	ath but not resulting	in the underlying cause	e given in Part I.	23e. Did to	obacco use o	contribute to th	e cause of death?
b, P.O. nires that the signed by t	d by	Atherosclerotic	Cardiovascula	r Disease			1 Ye			bly 4 🗸 Unknown
Division of Vital Records, tall or Attending Physician: The law require an increase and increase and increase has been sitted in by the funeral director, page 2 should be a belon in by the funeral director, page 2 should be a should b	Completed								4b. Were auto prior to cor death? 1 Yes	psy findings available mpletion of cause of 2 No
Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medica examiner?	Hannital:	. 🗖		Other			a 🗆 a ::	
1 of Vi ling Physi After this funeral dir	유	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Ir	tient 2 🗹 ER/Our		njury at Work?	ng Home 5 28d. Describe	Residence how injury or		
ision c Attending or death. rector: Af	ation		(Month, Day	(Year)	1	Yes 2 No				
Division Hospital or Attent 24 hours after death Funeral Director: tely filled in by the	Certification:	3 Suicide 6 Cou	28e. Place of (Specify)	Injury - At home, far	m, street, factory, office	e building, etc.	28f. Location (or Town, S		umber or Rura	Route Number, City
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical C		Physician: To the best of aminer: On the basis of ex and manner state	amination and/or in						
F S F S	ğ	29b. Signature and title of certifit				nse number			signed (Mont	h, Day, Year)
		30. Name and address of perso	n who completed cause of	death (Item 23a)		D.M.E.		iviaren	17, 2008	
		Pamela É. Southall, I	-	dical Examiner	111 Penn Stre	et, Baltimore,	MD 21201			
Si	ate	31. Date filed (Month, Day, Year	2008 32 Regist	rar's Signature	books					

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyolene.

Baltimore, Maryland 21215-0036

Phy /M Exa

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Division or Vital Records, P.O. Box 68760, 8+11

	Registrar Decedent's Name (First, Middle, L.)	ast)					2. Date of			3. Time of	Death
ın al	Ralph DeWit	t Condo	on				March	Day 14	2008	3:17	А
er	4a. Facility Name (If not institution, gi				4b. City, Town, or	Location of De			County of Dear		
	Carroll Lutheran	Village H	.C.Ce	ntei	Westmins	ter			Carroll		
	212-12-2892	Sex 7. A 1 ★ 2 ☐ F	ge (In yrs. Ia 90	st birth Yr	Months Days			Day, Year)	Co	thplace (State of buntry) cyland	r For
-	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town	or Location					10d. Inside Ci	ty Lin
ŏ	MD Carrol	1	TAZ	fboo	oine					1 □ Yes	2
Director	10e. Street and Number			- COG	10f. Zip Code			10g. Citi	zen of What Co	untry?	
	6820 Woodbine R	toad		21797				US			
Funeral	11. Marital Status	12. Was Decedent Armed Forces		S	13. Was Decedent of Hispanic Origin? (Specify Yes or No-				14. Race - Ame		
	1 ☐ Never Married 2 ☐ Married	1 Yes 2 If Yes, Give	No		1, ☐ Yes 2 ☑ No	Specify:	deno Hican, etc.)		Black, Whit		
p	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1942			2 - 1943					Specify: V	White	
etec	15. Decedent's E (Specify only highest g			16a. D	a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)					Industry (
Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		Electrician John Hopki.					1	
မှ ငြ	17. Father's Name (First, Middle, Las	et)		E_	lectrician	18 Mother's I	Name (First Mid			okins Al	<u>,</u> L
Be											
၉ .	George G. Cond 19a. Informant's Name/Relationship			10b A	Mailing Address (Street a		<u>.e Mae</u>	Bloc		Zin Code)	
								-		zip Coae)	
-	Freda Condon 20a. Method of Disposition	Wife	20b. Pla	ace of D	20 Woodbine Disposition (Name of	i	Date Date	-	21797 ecation - City or	Town State	
	1 ☑ Burial 2 ☐ Cremation 3 l		ce	metery,	crematory or other plac	· i			,		
- 1	4 Donation 5 Other (Specify) Morgan Chapel UMC CertMar 17 2008 Woodbine, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burrier—Queen Funeral Home										
	21. Signature of Pulleral Service Lice	27			1212 17 01	E T :	Burrier-(Queen	Funeral	Home	
+	23a. Part1. Enter the disease, or cor	mnlications that cause	d the death	Do no	1212 W. Old				ieia, M	ID 2178 Approximate	
	shock, or heart failure. List onl	y one cause on each l	ine.			_	^			Interval Bet Onset and I	wee
	disease or condition resulting in death)	a				art	fachere	٧		iyee	4
		Due to (or as	a consequi	Ince of)	:					,	
ē	Sequentially list conditions,	b. Due to (or as	i e consudia	eome of	k						_
in in	cause. Enter Underlying Cause (Disease or injury										
Examin	that initiated events resulting in death) Last	c Due to (or as	a conseque	ence of)	:						
Medical		u									
Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)							_	23d. Date of de Month		/ear
F P	Part II. Other significant conditions	contributing to death i	out not resul	ting in t	ne underlying cause give	en in Part I.	23e. D	id tobacco u	se contribute to	the cause of d	eath
d by							_ 1	☐ Yes 2	□ No 3 □ Pi	robably 4 🗃	Ínkr
Completed							24a. W	as an	24b. Were at	utopsy findings	 avai
E							— aı	itopsy erformed?	prior to death?	completion of ca	
ပို မ	25. Was case referred to medical	T	<u>.</u>			26 Diago of I	1□ Ye Death <i>(Check on</i>	s 2 No	1 □Yes	2 - No	
<u> </u>	examiner?	Hospital: 1 ☐ Inpati	ent 2□E	R/Outp	atient 3 DOA Othe	ar: /	g Home 5 ☐ R		e Clother (Cae		
<u>۲</u>	27. Manner of Death	28a. Date of Inj	ury	28b. Tir	ne of 28c. Injury		28d. Descri			еспу)	_
Certification:	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	ay Year)	Inju		k? Yes 2 ☐ No					
liga Liga	3 Suicide 6 Could not	be 28e. Place of in	jury - At hon	ne, farm	, street, factory, office				d Number or R	ural Route Num	ber,
erti	4 ☐ Homicide determined	building, e	tc. (Specify))			City or	Town, State)		
Medical C	29a. Certifier 1 Certifying F (Check only one) 1 Medical Exa	Physician: To the best aminer: On the basis of and manner s	of examination	/ledge, on and/	death occurred at the tin or investigation, in my o	ne, date and p pinion, death o	lace, and due to occurred at the tire	the cause(s) ne, date and	and manner as d place, and due	s stated. e to the cause(s)
ĕ.											
	bello	PY			D	52035		M	larch 1	4 2%	00
										1	- mary

		Please T	State of Mar		/ Depa		lealth a	-	Hygiei	ne	
\$ FE-12-		Registrar 1. Decedent's Name (First, Middle, Last)			Cei	Tifficate of	Death	2. Date			3. Time of Death
Physici /Medio		Vincent	Chasis					Marc	h 11,	2008 Yes	10:00 PM
Examir		4a. Facility Name (If not institution, give s	treet and number)			4b. City, Town, o	r Location o	f Death		4c. County of D	eath
		101 Bark Court 5. Social Security Number 6. Sex	7 400	(In yrs. last	hirthday)	Arno1d	If Under :	24 Hrs. 8. Date (of Rieth		Arundel
Funeral Director		213-30-7242	7. Age		Yrs.	Months Days	Hours	Min (Mont	h, Day, Ye. 9/193	a <i>r)</i>	Birthplace <i>(State or Foreigr</i> Country) arvland
pu ,		Usual Residence of Decedent		Ioc. City, To					-, -,		
faryla shov	ō	10a. State 10b. County				cation					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
the N 28a-1 notifi	Director	Maryland Anne Arur 10e. Street and Number	idel	Arno	Ta	10f. Zip Code			10g.	Citizen of What	Country?
th with 23a o	a D	101 Bark Ct.				210	12			USA	
r dea	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	13. \	Was Decedent of H	lispanic Orig	gin? (Specify Yes o	or No-		merican Indian, /hite, etc.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If then 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by F	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates:			1 □ Yes 2 X No	Specify:			Specify: W	Mhite
72 hou natura	ted	15. Decedent's Educ (Specify only highest grade	cation	1	6a. Deced	lent's Usual Occup	ation	t of working	16b	. Kind of Busine	ss/Industry
Athin ne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		_	kind of work done DO NOT use retire	d)	or working			
filled v Hygie thert		11th 17. Father's Name (First, Middle, Last)			U	vner	18. Mothe	r's Name (First, M		Automot:	ıve
lid be fental ked o	To Be	Charles P. (Chasis					elaide S		,	
Shou and N is mai		19a. Informant's Name/Relationship (Typ	pe. Print)	1	19b. Mailir	g Address (Street	and Numbe	er or Rural Route N	lumber, Ci	ty or Town, State	e, Zip Code)
and and m 27		Patricia A. Chasis	s/ Wife	Ook Blass				old, Mary			
ages 1 nt of h : Fife		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State			sition (Name of natory or other pla	ce)	Date 3/12/08		Location - City	
nit. Partme		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature M Fine Al Septice License	ee	Nal		rematory 2. Name and Addre				dgewate:	
one on one of		Mulle						George Sland Ro			eral Home r. Md. 2103
		23a. Part1. Enter the disease, or complications shock, or heart failure. List only on	cations that caused the cause on each line	ne death. D							Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)		- ca							Onset and Death 2 month
/Medical Examiner		Toolaning in dollari,	Due to (or as a	consequent							V.C.C.C
	Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a								YEUS
be executed ician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									
be executed sician and burial-transit	alEx	resulting in death) cast	Due to (or as a	consequen	ce of):						
death certificate attending physicate for use as the h	edica	d				-					
h certi	In/M	23b. Was decedent pregnant	3c. If yes, outcome pf 1□Live birth 2	pregnancy		Totosio manus				23d. Date of	delivery
e deat he atte	Physician/Medic	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at til]Ectopic pregnanc]Other <i>(specify)</i> _	у		_	Month	Day Year
hat the		9 ☐ Unknown Part II. Other significant conditions con		not resultin	a in the ur	derlying cause giv	en in Part I	23e.	Did tobaco	co use contribute	e to the cause of death?
The law requires that the death certificate tee has been signed by the attending physoage 2 should be detached for use as the	d by		g to do an in our		g a a.	actioning access give			1 ☐ Yes	11	Probably 4 Unknown
aw req s beer 2 shou	olete								Was an	24b. Were	autopsy findings available to completion of cause of
The lav	Completed								autopsy performed 'es 2 🔀	3 death	1?
sician: The certificate l	Be (25. Was case referred to medical examiner?	ospital:			04		of Death (Check of	nly one)		
Physic ruthis or rall din	: To	1 ☐ Yes 27 No	1 ☐ Inpatient		Outpatien b. Time of		4 LI Nu			6 Other (S	Specify)
nding ath. r: Afte e fune	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury	28c. Inju Wor M 1	rƙ? Yes 2∐i			,,	
ir Atte ter deg irecto	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury building, etc.	- At home (Specify)	, farm, str	eet, factory, office		28f. Locat	ion (Street or Town, St	and Number or	Rural Route Number,
pltal o		29a, Certifier 1 Certifying Phys	ician: To the best of	my knowle	dae deeth	a accurred at the ti		d place and due to	the cause	-(a) and man-	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	edical		ner: On the basis of e and manner state	xamination							
To th within To th comp	Me	29b. Signature and title of certifier				29c. Licens	e number		29d.	Date signed (Me	onth, Day, Year)
		Mainell	rak	MI	7	D45	297			larch 11	1208
11112		30. Name and address of person who co			, , , , ,	,					
',	te	Elaine M. Arata, 1 31. Date filed (Month, Day, Year)	32. Revistrar'	s Signature		1 .	erna F	ark, MD	21146	1	
Registr		MAR 132	008	un s	or 1	good					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 03 Year **Physician** ode E JORIE 1510M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1202 John Ross Ct. Anne Arundel Crownsville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1□ M 2 Months Days Hours NY 9/1/1926 81 037-16-7605 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County MD Crownsville 1 ☐ Yes XXNo Anne Arundel Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21032 1202 John Ross Ct. USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify. White 3 ₩ Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Animal Welfare Institute Assistant Director 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul Frederick Kullberg Kathryn Frances မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hillary Myers 26 Mast Rd. Lee, NH 03861 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Metro Crematory 3/13/2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fungral Service Licer 22. Name and Address of Facility Hardesty Funeral Home, P.A. Oat, Annapolis, MD 21401 12 Ridgely Ave. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Vario **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician the as asn. IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 ☐Unknown Were autopsy findings available prior to completion of cause of page 2 s autopsy performed? Yes 2.2 No death? 1 ☐ Yes 2 ☐ No certificate or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₹¶0 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27 Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1. Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b Signature and title of certifier

5 CH State

31. Date filed (Month, Day, Year)

11 HAR

MAR 1 3 2008

Name and address of person who completed cause of death (Item 23a) (Type, Print)

FENTA

00

32. Refetrar's Signature

445

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 11:45 PM ollins 03 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5. Social Security Number 6. Sex Darchester turlock Age (In yrs. last birthday) If Under 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2X F 215-52-9912 Director 60 22, 1947 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Maryland Dorchester Hurlock 1 ☐ Yes 2\times\t Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4329 Blinkhorn Road 21643 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2000 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo White by Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maid Housekeeping 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles R. Griffin, Sr. Lois M. Griffin ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James M. Collins/husband 4329 Blinkhorn Road Hurlock, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ Removal from State Hillcrest Mem. Gardens 3/17/2008 Annapolis, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licensee 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Canton **Physician** Lun /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 Live birth 2 Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 4□Pregnant at time of death P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 XYes 3 Probably 4 Unknown 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autopsy performed? Yes 2 No Division or Vital To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 5 Residence 6 □Other (Specify) P 1 🗌 Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 1 Natural 5 Pending investigation 2 No 2 Accident To the Funeral Director: completely filled in by the 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maintenance.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of co

31. Date filed (Month, Day,

32. Registrar's Signature

costel

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GERRE!

29c. License number

Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State amend 8 per F.H. g880 6/2/Official of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Youzith Bautista Carmona 12:07 M Haxel 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. | 8. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 128M 2 F Hours Yrs. Maryland None Director Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Annapolis 1 **T**Yes 2 □ No Director Anne Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Madison Street 21403 U.S. A. 1000 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ ☎0
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Peges 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Antif item 27 is marked other than "naturel, or ite,
any or other traumatic event, the Mudical Experimenty or other traumatic event, the Mudical Experiment. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Deves 2 No Specity: Mexican Specify: Hispanic 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) NIA Elementary/Secondary (0-12) College (1:4or 5+) NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Rayner Benito Bautista Herrera Itazzibe Carmona Lopez ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mother Madison St. # BI Annapolis, Md. 21403 Hazzibe Lopez 1000 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Geremation 3 Removal from State permit. Pege Department of Important: If any injury or once. 2/21/2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 21. Signature of Funeral Service Deepsee 22. Name and Address of Facility Hardesty Funeral Home, P.A. Annapolis, Md 21401 12 Ridgely Ave. 23a. Part 1 Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Overwhelming Physician day /Medical Due to (or as a consequence of): Examiner Prematurit Extreme 1 day Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 → 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificete 1 ☐ Yes 2 ☐ No 2 No 1 Yes ours efter death.

neral Director: After this certific filled in by the funeral director. 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Wo 1 Sepatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Satural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours eft To the Funaral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner effect. 29a. Certifier Medical 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 047158 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

2001

MD

32. Registrar's Signature

in

Yann

2008

Jann-

31. Date filed (Month, Day, Year)

Medical Pkny Annapolis, Md 21401

08 Ro

-02029 obert J. Davis, Jr.		Please Type or F	rint in Blac Maryland / D	k Inde epartn	lible Ir nent of	i k. Ensur Health ar	re All Cor nd Mental	oies Are Hygiene	Legib	ole.		
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		or State	,	Certifi	cate of	Death			Reg. N	No	201	18 1005
Physician/	1.1	istrar Decedent's Name (First, Middle,Last)						2. Date of Month	n Da		Year	3. Time of Death 1512 hrs
ledical Examiner		Robert Joseph Davi			- 1	1b. City, Town, o	r Location of De		h 12, 20		nty of Death	
	4a	Facility Name (if not institution, give street	eet and number)		T I	Ocean City				Worce		
Funeral	5.	Social Security Number 6. Sex	7. Age (Ir	yrs. last b	irthday)	If Under 1 Ye			e of Birth (N	MM/DD/Y	YYY) 9. Birtl Cou	hplace (State or Foreign untry)
Director		220-98-7947 1 M	2 F 4	2	Yrs	Months Da	ys Hours	Min. 5/	25/19	965		MD MD
		ual Residence of Decedent		011 T	vn or Locat							10d. Inside City Limits
w any	10	a. State 10b. County			ın Cit							1 Yes 2 No
Maryland 28a-f show any d at once. ector	10	MD Worceste	r	ocea		10f. Zip Code			10g.	Citizen of	f What Cour	ntry?
ith the Maryland 23a or 28a-f sho notified at once	10	405 142nd St.				2184	.2		ļ	USA	4	
15-0036 filed within 72 hours after death with the Maryland filed within 72 hours after death with the Maryland II Hygiene. ed other than "natural", or items 23a or 28a-f she i, the Medical Examiner must be notified at once of Commission by Fumeral Director			. Was Decedent Ev	er in U.S.	13. Wa	as Decedent of H res, specify Cub	lispanic Origin	? (Specify Ye	es or No-		Race - Ameri Vhite, etc.	ican Indian, Black,
or items 23	1	Never Married 2 Married 1	Armed Forces? Yes 2 X	No				derito ritodii, c	,,	Spec	UII.	nite
ral", o	3	Widowed 4 Divorced If Y	Dates:	-10-d\ 16		Yes 2 X N		d of work don	ne 1		of Business/	
hours natur Exam		15. Decedent's Education (Specify only become start of the secondary (0-12)	College (1-4 or 5+)		during n	nost of working li	fe. DO NOT us	e retired)				
36 nin 72 s. than "diest	2	Elementary/Secondary (0-12)	2		Exe	cutive (–	staura	ant
15-0036 filed within 72 hours afth Hygiene. d other than "natural", the Medical Examina Commission Div	1	7. Father's Name (First, Middle, Last)						Name (First, I			iame)	
21215-0036 July be filed within 7 Mental Hygiene. marked other than ic event, the Medic	2	Robert J. Davis, S	r.		10h Mailir	ng Address (St	Dar	lene C	oute Numb	er, City or	Town, State	e, Zip Code)
O to B is # 1		9a.Informant's Name/Relationship (Type Darlene Lashley /			13	B Cotto	on Ave.	, Port	erdal	e, G	A 3007	70
≥ da a la	13	On Method of Disposition		20b. Pla	ce of Dispo	sition (Name of	cemetery,	Date		20c. Loca	ition - City o	r Town, State
		Burial 2 X Cremation 3	Removal from State	Can	-	other place) Topen Ci	rem.	3/17/	08	Fra	nkfor	d, DE
Baltimore, permit. Pages I at Department of Het Important: If ite injury or other tr	2	Donation 5 Other Specify: 1. Signature of Funeral Service Licenses		1000	22.	Name and Addr	ess of Facility	The B	urbag	e Fu	neral	
Balti permit. Departm Imports	1	VIND TIME	x ncm			108 Wil	liam St	., Ber	lin,	MD 2	1811 or heart	Approximate Interval
Physician	1/2	3a/ Part I. Enter the disease, or complicing failure. List only one cause on each	me.			the mode of dyl	ng, such as car	diac or respir	atory arres	, 51100K,		Between Onset and Death
aminer			astrointestinal h									
	1	_b Li	ver Cirrhosis	dende on,								
1			e to (or as a consec hronic Alcohol A									s.
	E١		ie to (or as a consec									
ecuted and transit	등 - 등	d										
be exe		UNPENDED	AMENDED							23d. D	ate of delive	ery
Box 68760, re death certificate be executed the attending physician and ned for use as the burial - transi	Physician/Medic	F FEMALE: 3b. Was decedent pregnant in the	23c. If yes, outcom 1 Live birth	e of pregna		Fetal death	3 Ectopic	pregnancy			onth	Day Year
x 68 th certi	cia	past 12 months? 1 Yes 2 No 9 Unknown	4 Pregnant at t	ime of dea	th 5	Other (Specify)				1		
Bo ne deat t the at	ž Į	1 Yes 2 No 9 Unknown Part II. Other significant conditions	9 Unknown	but not res	sulting in th	e underlying cau	use given in Par	rt I.	23e. Did to	bacco use	e contribute	to the cause of death?
P.C.	ব্র	Atherosclerotic Cardiovaso							1 Yes	2 1	lo 3 √ P	robably 4 Unknown
ds, l	Completed	714107000101010							24a. Was a autop		24b. Were prior t	autopsy findings available to completion of cause of
COF	힐									med?	death 1 ✔	
tal Recol		25. Was case referred to medical				26.1	Place of Death	(Check only o				
Vital Fysician:	m۵		ospital: 1 Inpatie	nt 2	ER/Outpati			Nursing Hor			e 6 🗸 Ot	ther: Scene
1 of Vi ling Physi After this funeral dir	삵	27. Manner of Death	28a. Date of Inju (Month, Day Y	ry ear)	28b. Time	' ' '	Injury at Work Yes 2	. 1	Describe I	now injury	occurred	
ion tendin leath.	aţio	1 ✓ Natural 5 Pending 2 Accident Investigatio	n						Location (Street and	Number or	Rural Route Number, City
Division pital or Attent ours after death reral Director:	Certification:	3 Suicide 6 Could not b	28e. Place of In	jury - At ho	me, tarm, s	street, factory, or	nce building, et		or Town, S			
Dospital hours		4 Homicide	~	v knowledo	e, death o	courred at the tin	ne, date and pla	ace, and due	to the caus	se(s) and	manner as s	stated.
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) 2 Medical Examiner:	On the basis of examend manner stated.	mination ar	nd/or invest	tigation, in my or	oinion, death oc	curred at the	time, date	and place	c, and add .	
To wit	Me	29b. Signature and title of certifier	and mariner stated.	-			icense number				ate signed(h 13, 200	(Month, Day, Year)
		When Brass	ell me	7			D.C.M.E.			iviaic		
0.01		30. Name and address of person who o	-intent Modica	Evamir	or 11	1 Penn Stre	et. Baltimor	e, MD 212	201			
BAG			22 Polietra	r's Signatu	ire g ,		,					
St	ate	31. Date filed (Month, Day, Year) 7 2	008 32. 186	w.	15 1	Gode						

DHMH 17 Rev 1/2001 OCME 2006

Registrar

			Please	State of M		d/D	epartment	of Health and			9	
10 E			 State Registrar Decedent's Name (First, Middle, La 	ast)			Certificate -		2. Date of		2,000	3. Time of Death
	Physici /Medio	al	Andre 4a. Facility Name (If not institution, give	e street and number.)	\mathcal{D}	erring 4h City To	wn, or Location of De	Man	ch a	Day Year 2008 4c. County of Deat	
	Examir	er	The Johns Hopki	ns Hospit		last hirth	Balt	imare C	ity	of Birth	Baltime	ore
1	Funeral Director			1 X M 2□F		54 Y	Months [Days Hours Mi	n. (Monti	n. Dav. Ye:	1954 Wash	nplace (State or Foreign untry) ington, DC
	Maryland f show ied at	or	10a. State 10b. County Maryland Baltimo	re		ty, Town	or Location					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	with the fa or 28a-t be notif	Direct	10e. Street and Number unknown	10	Ба	T C TIII	10f. Zip Ci unkn				Citizen of What Co	untry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any lury or other traumatic event, the Medical Examiner must be notified at anone.	by Funeral Director	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces' 1 Tyes 21 If Yes, Give Year or Dates:	Ever in U ? No	.S.	13. Was Deceder If Yes, specify	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2☐ No Specify:			14. Race - Ame Black, White	e, etc.
21215-0036	in 72 hour n "natural fedical Ex	Completed t	15. Decedent's E (Specify only highest gr	ducation ade completed)					Kind of Business/	Black Industry		
d 212	filed withi Hygiene. ther thar int, the N	Comp	Elementary/Secondary (0-12) 9th grade 17. Father's Name (First, Middle, Lasi	College (1-4or	5+)		Disabili	ty (Medic			one	
Maryland	ould be a Mental arked o atic eve	To Be	Clifton Derringto	n					Carrani	ı Ham	pton	
Mar	and 2 sh alth and 27 is m er traum		19a. Informant's Name/Relationship Dianne Hampton/si	,		1		Street and Number or S Avenue.				
Baltimore,	Pages 1 and the rent of He rent of Item Int: If Item Inty or other		Dianne Hampton/sister 609 - Clovis Avenue, Capitol Heights, Md.									
Balti	permit. Departri Importa any injt		21. Signature of Funeral Service Lice	nsee MD #				Address of Facility Funeral				
	\$		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	1.4	1	h. Do no	t enter the mode of	of dying, such as card	iac or respirate	ory arrest,	2011, D. C	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as	o (or as a consequent, of):						30 hours	
à.	p #s	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	-):					E
,092	e be executed sician and burial-transit	sal Examiner	that initiated events resulting in death) Last	c. Hepai	hTs a conseq	uence of):					3 years
O. Box 68	law requires that the death certificate as been signed by the attending physics should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 ☐ Feta	al death	3 ☐ Ectopic preg 5 ☐ Other (spec				23d. Date of del Month	ivery Day Year
Ω.	quires that in signed by uld be deta	ρ	Part II. Other significant conditions	contributing to death b	out not res	ulting in t	he underlying cau	se given in Part I.		Did tobacc	co use contribute to	the cause of death?
l Records,	о <u>г</u> о	Completed							-	Was an autopsy performed 'es 2X	prior to o	topsy findings available completion of cause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				26. Place of E				
ō	ing Affel une	ion: To	1 Yes No 27. Manner of Death 1 Natural 5 Pending	Hospital: Inpati	ury	28b. Tii	ury	. Injury at Work?			e 6 □Other (Spen hjury occurred	pify)
ivision	r Attending ter death. irector: Afte ir by the fune	tification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	e oge Place of in	jury - At ho tc. <i>(Specif</i>	ome, farn fy)	M n, street, factory, c	1 ☐ Yes 2 ☐ No	28f. Locat City o	on (Street r Town, St	t and Number or Ru tate)	ıral Route Number,

Division or Vital Records, P.O. Box 68760, To the Hospital or Attendil within 24 hours after death.
To the Funeral Director: A completely filled in by the fu

> State Registrar

Medical Certifical

29a. Certifier (Check only one)

29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

RES-000

29d. Date signed (Month, Day, Year)
March 2, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day March **Physician** 2008^{Year} 7, Edwin 9:08P. J. Dudka /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** July 16, 1929 78 Days Hours Min. 1 XM 2 ☐ F New York Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 X Yes 2 □ No Maryland Prince George's University Park Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 4007 Van Buren Street 20782 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo White δ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1.2 College (1-40L5+) Federal Government Engineer other 17. Father's Name (*First, Middle, Last)* Joseph Dutka 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event Be Anna Giermek 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4007 Van Buren Street University Park, Md. 20782 19a. Informant's Name/Relationship (Type. Print) Claire I. Dudka -wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐Removal from State Metropolitan Crematory 3/13/2008 Alexandria, Virginia 0 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Aspiration Pneumonia /Medical Due to (or as a consequence of): Examiner Cardiopulmonary Arrest Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending PhysIclan: The law requires that the death certificate be executed Coronary Artery Disease Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an was ...
autopsy
performed?
Yes 2 X No death? 1∐ Yes 2 XNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 7 1 ☐ Yes 2 💢 No 1 Inpatient 2X ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one)

Division or Vital Records, P.O. Box 68760 24 hours a e Funeral I within 2

Baltimore, Maryland 21215-0036

Registrar

31. Date filed (Month Pay Year) 4 2008

29b. Signature and title of certifier



29c. License number

D46998

29d. Date signed (Month, Day, Year) March 7, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2008 6:30 a Deike1 March 12, Geneveive Ann /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 □ M 2 1 F West Virginia 577-32-3890 82 Nov. 20, 1925 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 11500 Maple View Drive 20902 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐No Specify þ Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accounts Payable Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward M. Brown Mary Hurley ဥ 19a. Informant's Name/Relationship (Type. Print)
Paula A. Caldwell/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 6141 Leesburg Pike, Falls Church, VA 22041 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State March 14 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2008 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that causes the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Respiratory Failure Due to (or as a consequence of) Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day

Physician /Medical Examiner

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any linjury or other traumatic event once.

Funeral

Director

a or 28a-f show be notified at

ral", or items 23a Examiner must b

"natural", or

the Maryland

e filed within 72 hours after death with tal Hygiene. other than "natural", or items 23a or 5

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed burial-trar the

attending physiciar as nse ō detached the signed if page 2 s has certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral

Be

Certification: To

Medical

Division or Vital Records, P.O. Box 68760,

1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown									
Part II. Other significant condition Pneumonia	s contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ★ Yes 2 No 3 Probably 4 Unknow								
		24a. Was an autopsy performed? 1 □ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No								
25. Was case referred to medical	26. Place of Death (Check only one)									
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	Home 5 ☐ Residence 6 ☐ Other (Specify)								
27. Manner of Death Ŷ∄Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Day Year) Injury Work? tion M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred								
3☐ Suicide 6 ☐ Could no 4☐ Homicide determin		28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	Physician: To the best of my knowledge, death occurred at the time, date and place, xaminer: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.									

State Registrar

Alan R. Segal, MD 31. Date filed (Month, Pap Year)

ein

2008

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number D52261 29d. Date signed (Month, Day, Year)

March 13, 2008

1517 Mugo Circle, Silver Spring, MD 20902

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Amend Item 23d, 25 per mean 877 i 03/26/08 dhb 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 29 2008 FEB. 12:10A NATHANIEL L. DUNSON, SR. /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner SOUTHERN MARYLAND HOSPITAL CLINTON PG Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 74 Yrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1X M 2□ F 6/17/33 OHIO Director 299-26-8343 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show at 1 Yes 2 No a or 28a-f sh t be notified PG MD CLINTON Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number death with 20735 23a 9106 PINEVIEW U.S.A. "natural", or items 23a dical Examiner must Funeral 12. Was Decedent Ever in U.S.
Armed Forces? 1952
1 XYes 2 No
1 Yes, Give
Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 □ Yes 2 🔀 No Specify BLACK þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) marked other than CARPENTER PUBLIC WORKS 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Health and Mental em 27 is marked o 1 and 2 should be ANGELIA BARBER ROBERT DUNSON traumatic (ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ~2074419a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any injury or other trau 288 HARRY S. TRUMAN DR. UPPER MARLBORO, MD TRACEY LOMBRE/STEP-DAUGHTER 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition MARYLAND VETERAN 3/10/08 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) CHELTENHAM, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility STRICKLAND FUNERAL SERVICES 23a. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 6500 ALLENTOWN RD. CAMP SPRINGS, MD 20748 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to l a consequence of) Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine requires that the death certificate be executed burial-transit and Due to (or a a consequence of) Box 68760, physician Sigmoid Volvulus Physician/Medical the as IF FEMALE: for use 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.O. ed by the a detached f 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ð 2 No 3 Probably 4 Manknown 1 □ Yes page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 2□ No 1 TYes 2 No 1 Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Hospital or Attending Pl 24 hours after death.Funeral Director: After the 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide 24 hours a 1🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated. within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAR 2 6 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 21, 2008 8:45A March Tamika Μ. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Gilchrist Cento Examiner Towson

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Baltimore Hospice of Baltimore enter Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** 1 ☐ M 2 ☑ F Director 564-89-8130 Dec.26,1968 Md Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show deal Examiner must be notified at 1 Yes 2 No Director Md. Baltimore Randallstown 10g. Citizen of What Country? 10e. Street and Number 21133 United States permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23: any Injury or other traumatic event, the Medical Examiner must by Funeral 3434 Carriage Hill Circle 12. Was Decedent Ever in U.S.
Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Administrative</u> <u>Private</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carolyn Scott ၉ Ollie Vaughn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3434 Carriage Hill Circle Randallstown, Md. 21133

Place of Disposition (Name of cemetery, crematory or other place)

3/28/08 Melvin Evans/husband 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 3/28/08
Riverdale Park Crematory 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Riverdale, Md. 22. Name and Address of Facility Hodges & Edwards F.H. 21. Signature of Funeral Service Licensee Suitland, Md. 20746 3910 Silver Hill Rd., inna 23a. Part Enter the disease, or complications that a shift, or heart failure. List only one cause on d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Liter University Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 5 Other (specify) ☐Yes 2 No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an within 24 hours after death.

To the Funeral Director; After this certificate has leampletely filled in by the funeral director, page 2 seconpletely filled in by the funeral director, page 2 seconpletely filled. autopsy performed 2 No 1∐ Yes 2FTNn 25. Was case referred to medical Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation (Month, Day Year) Injury 1 Natural 1 ☐ Yes 2 ☐ No M 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 25205 MArch 21,2008

State Registrar 31. Date filed (Month, Day, Year)

MAR 28



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Ershler 12 1:22 AM March 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Months Days Hours 1 □ M 2 🗙 F Director 87 March 8, Canada 238-26-1451 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 📉 No Maryland Montgomery Rockville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20850 United States 1235 Potomac Valley Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Vending Machine Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elias Beryl Ershler Fannie Schnitzer မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Olmstead Court, Rockville, MD 20854 Sonya Okin, Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State N Burial 2 □ Cremation 3 □ Removal from State High Pt. Hebrew Ce. March 14,2008 High Point, NC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 21. Signature of Fungral Service License 254 Carroll St., NW Washington, DC 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Gastrointestinal immediate disease or condition resulting in death) Due to (or as a consequence of): days Coagulop at hy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) as the burial-IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 ☐Ectopic pregnancy ō in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) 1□Yes 2XNo detached 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy performe 1 Yes 2 No Be Check only one) 2

Physician /Medical Examiner The law requires that the death certificate be executed

Baltimore, Maryland 21215-0036

attending the ģ certificate within 24 hours after death.

To the Funeral Director: After this certific: completely filled in by the funeral director,

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician:

5 ☐ Residence 6 ☐ Other (Specify) d. Describe how injury occurred 3f. Location (Street and Number or Rural Route Number, City or Town, State)

To Be C	25. Was case referred to medical examiner? 1 ☐ Yes 2 2 No	Hospital: 1 ☐ Inpatient 2区	ČER/Outpatient 3□	26. Place of De	
	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28
Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ome, farm, street, fac y)	otory, office	28

🛛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

one)	and manner stated.
29b. Signature and title of certifier	The so

29a, Certifier

29c. License number 29d. Date signed (Month, Day, Year) March 12: 2008 40051791

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Tamara L. Kile, D.O. 9901 Medical Center Drive, Rockville, MD 20850 Tamara L. Kile, D.O.

State Registrar

Medical

31. Date filed (Month, Day, Year) MAR 1 4 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 12 per th 28/9 5-6-08 vt
State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	State of Maryland /	•	ment of H ficate of L		,	giene Reg. No. 🥎 🎧	0.0	10000
Ľ	Physicia	an	1. Decedent's Name (First, Middle, Las-	r) Ralph	EAS ⁻	TON		2. Date of De	ath C U	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give				Location of Death	March	11, 2008		6:50 P M
	Examin	er	Laurel Regional He			Laure	_				eorge's
	Funeral Director		5//-28-8191	7. Age (In yrs. last to		Under 1 Year lonths Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Jan. 11	th ly, Year) 1920	9. Birthp Coun Wash	lace (State or Foreign try) nington, DC
	Maryland -f show fied at	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Montgome	ery Si		on Spring				1	0d. Inside City Limits 1 ☐ Yes 2 ☑No
	th with the 23a or 28a ust be noti	Funeral Director	10e. Street and Number 3156 Gracefield R	oad #103	1	10f. Zip Code	20904		10g. Citizen of W		-
036	be filed within 72 hours after death with the Maryland Ital Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 💢 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 WILL HYPS WWII If Yes, Give Year or Dates:		s Decedent of Hi es, specify Cuba Yes 2 No	spanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		e - Americ k, White, · Whi	
Maryland 21215-0036	within 72 h iene. than "natu ihe Medical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation 16 de completed) College (1-4or 5+)	ia. Decedent (Give kind life. DO Paper	t's Usual Occupa d of work done o NOT use retired, Mill	16b. Kind of Bu		-		
_	9 m 0 5	To Be Co	17. Father's Name (First, Middle, Last)	Hyman Epstein			18. Mother's Name ROSE	(First, Middle Kasofs	L , Maiden Surnam SKY	e)	
, Mary	es 1 and 2 shount Health and Notes item 27 is main other trauman		19a. Informant's Name/Relationship (T Stacy Easton Gree	ne, Daughter 41	.06 De	catur A	ve., Kens			~ ~ - '	Code)
Baltimore,	permit. Pages 1 and 2 should b Department of Heath and Ments Important: If item 27 is marked any injury or other traumatic e-		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State Metro		on (Name of ory or other place an Cremo		Date 3/13/08	20c. Location -	-	ia, VA
Eg Call	permit Depart Import any in		21. Signature of Funeral Service Licens		254	Carrol	s Hebrew F 1 St., Nh	l. Wash	ington.	DC 2	20012
	Physician		23a. Part1. Env.r the disease, or comp shock, heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a Pneumonia		he mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death 1 Week
	/Medical Examiner			Due to (or as a consequence	e of):	- 1					
	Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.								
68/60,	tificate be executed g physician and as the burial-transit	edical Exa	resulting in death) Last								
EOX	ath cer attendin for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 4□Pregnant at time of death 9□Unknown		topic pregnancy ther <i>(specify)</i>			23d. Dat Mor	e of delive	ery Day Year
ras, F	w requires that the de been signed by the should be detached		Part II. Other significant conditions co	untributing to death but not resulting	in the under	rlying cause give	en in Part I.				ne cause of death?
Lec	The lar ate has page 2	Completed by						24a. Was auto perfo	psy prmedy? p	Were auto prior to con leath? Yes	psy findings available mpletion of cause of 2 ☐ No
VII a	sician; certific rector,	Be	25. Was case referred to medical examiner?	Hospital:		3 DOA Othe	26. Place of Deat				
on or	ing Phy After this uneral d	tion: To	1 Yes 3 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	. Time of Injury	28c. Injury Work	4 Li Nursing no		dence 6 Other		y)
	F 9 F C	Certification:	3 Sulcide 6 Could not be 4 Homicide determined	1	farm, street,			28f. Location (City or To	Street and Numbers, State)	er or Rura	d Route Number,
	To the Hospital or A within 24 hours after or To the Funeral Direct completely filled in by	Medical C	29a. Certifier (Check only one) 1	ysiclan: To the best of my knowled inner: On the basis of examination a and manner stated.	ge, death oc and/or invest	ccurred at the tin tigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time	cause(s) and ma date and place,	nner as s and due to	tated. o the cause(s)
		M	29b. Signature and title of certific	washo		29c. License D 24			29d. Date signed March		
	10+1		30. Name and address of person who of Mark Parkhurst, M.	.D., 3110 Gracef	i) (Type, Prin	Road, Si	lver Spr	ing, MD	20904		
	Sta Registr	te ar	31 Date filed (Month Day Vear)	32. Signature							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 008 2. Date of Death 1. Decedent's Name (First, Middle, Last) MARCH 09 Day 2008 Year **EGGERS** 0015 PAMELA SUE 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ALLEGANY CUMBERLAND WMHS-Memorial Campus If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign Days 1 M 2 X F Months 217-78-7828 46 Maryland Aug. 1, 1961 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 117 Yes 2 No Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 112 Memorial Ave. USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 🙀 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Housekeeping Nursing Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Clay Beitzel Mary Maxine Miller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 459 Bill Beitzel Rd., Grantsville, MD Melanie D. Beitzel/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 □Removal from State 4 □ Donation 5 □ Other (Specify) Country Side Crematory March 11,2008 Davidsville, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, P.A. Ulmai 21536 P.O. Box 275, Grantsville, MD 23a. Part1. Enter the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Months Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Year of death? nknown ngs available

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

ģ

Completed

Be ပ MD

Funeral

Director

Department of Health and Mental Hygiene. Important: or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

with the Maryland

72 hours after

Pages 1

Baltimore, Maryland 21215-0036

Examiner The law requires that the death certificate be executed and burialphysician Physician/Medical attending pl ed by the a ģ has page 2 Hospital or Attending Physician: 9 P within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Division or Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		2		te of delivery onth Day	
Part II. Other significant condition	s contributing to death but not resulting in t	the underlying cause given in Part I.	23e.			ribute to the caus 3 ☐ Probably	
			24a.	Was an autopsy	1 1	Were autopsy find	

eq						1 ☐ Yes 2	☐ No 3 ☐ Probably 4 🔯 Onknov
Completed						24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings availat prior to completion of cause o death? 1 □ Yes 2 □ No
ation: To Be	25. Was case referred to medical examiner?		Place of Deat	h (Check only one)			
	1 ☐ Yes 2 No	Hospital: 1 ☐ npatient 2 ☐	ER/Outpatient 3 🗆 🛭	OOA Other: 4	☐ Nursing Ho	me 5 Residence 6	G □Other (Specify)
	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigat		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes	1	28d. Describe how injury	y occurred
Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ome, farm, street, factory)	ory, office		28f. Location (Street and City or Town, State)	d Number or Rural Route Number,
edical (Physician: To the best of my kno aminer: On the basis of examina and manner stated.					
ž	29b. Signature and title of certifier		2:	9c. License nur	nber	29d Date	e sinned (Month, Day, Year)

29b.	Signature and title of certifier	
	SERVE	
	CONT	

29c. License number D62929 29d. Date signed (Month, Day, Year)

2008

MARCH

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Osei Bogunah 500 Memorial Ave Cumberland, MD 21502 Emmanuel M.D 32. Registrar's Signature

State

To the

08-02195

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Type of Finite in Die	toll illidollate		
1 1/	D	1114	Montal Hygian
State of Maryland /	Department of	meaith and	Mental Hygien

Elipaic / al cobico / a c							
ealth and Mental Hygiene	200	10	-	0		6	8
eath	 - CUL	10	i.	الب	\cup	U	V

Herbert Paul Eise		ert - For State	S	ate of Mary	iand / D	epartm Certific	nent of l cate of l	Health an Death	nd Ment	tal Hygiene		Na	200	8 1	0068
		Registrar 1. Decedent's Name	e (First Mido	lle Last)		Certino	Jate of I			2. Date o				3. Time of De	eath
Physician Me al Examin										Month March	19, 20	308 	Year	0740 hr	S
		HERBERT 1 4a. Facility Name (i	f not instituti	on, give street and	number)		4b	. City, Town, o	r Location o	of Death		4c. Cou	inty of Death		
		1700 Ridge	ly Street					Baltimore				<u></u>		NONE	
Funeral		5. Social Security N	lumber	6. Sex	7. Age (I	n yrs. last bi	irthday)	If Under 1 Ye			of Birth(I	им/DD/Y 22,	Foreig		l
Director		179-48-66	583	1 X M 2 F		49	Yrs.	Wierrais	,5 1.00.0			<u> 195</u>	8 PE	VIVSYLVA	ANIA
, h	ļ	Usual Residence o 10a. State	f Decedent		10	c. City. Tow	n or Locatio	n						10d. Inside (City Limits
ow any		MARYLAND		NONE		,,		BALTIM	ORE					1 X Yes	2 No
ryland a-f sh	횽	10e, Street and Nu					— Т	10f. Zip Code			10g.	. Citizen o	of What Cour	ntry?	
easth with the Maryland or items 23a or 28a-f show must be notified at once.	ΦI	605 UMBRZ		ET					212	24		UNI	TED ST	ATES	
with the 13 and 16 and		11. Marital Status		12. Was D	ecedent Ev	er in U.S.	13. Was	Decedent of H	lispanic Orig	gin? (Specify Yes n, Puerto Rican, et	or No-		Race - Ameri White, etc.	ican Indian, B	llack,
death ritem	Funeral	1 Never Marri		Vialified 1X Yes	Forces?	No	,				0.,	l l	5.777	म्पष्ट	
after all, o		3 Widowed		ivorced If Yes, Give or Dates:			_	Yes 2 X N		kind of work done	11		of Business/		
hours	<u>8</u>	15. Decedent's E Elementary/Sec		ecify only highest g	rade comple (1-4 or 5+)		during mo	st of working lif	fe. DO NOT	use retired)		02.74.14		,	ļ
36 nin 72 s. than than	ble	12	oridary (0-12		_		WELL	DER/FAB	RICAT	OR			STE	EL	
5-0036 iled within 77 Hygiene 1 other than	Completed by	17. Father's Name	(First, Middl	e, Last)					18.Mothe	r's Name (First, M	iddle, Ma	iden Sum	name)		
215 be file rked c		PAUL LEV	ERE EI	SENHART_						RDELIA S			T 0111	- 7:- Ondo)	
5 a M d d 2	ဥ	19a. Informant's N	ame/Relatio	nship (Type, Print)	ar.	1	19b. Mailing	Address (Str	eet and Nur	mber or Rural Rou BALTIMO	RE.	ar, City o	LAND 2	21224	
MD and 2 sho alth and 27 is raumati		20a, Method of Dis		MUNKT/ WIT				tion (Name of		Date				r Town, State	
Baltimore, permit. Pages I an Department of Hea Important: If iter				on 3 Remova	I from State	CHES	APEAK	E PEREMA		MARCH 2	2008	डग र ्ग	FNSVTI	LE, MAE	RYLAND
timent riant:	Ш	4 Donation 5	Other			CENT	22mN	ame and Addre	sss-of-Facili	FELLOW	S HE	LFE	NBEIN	1 & NE	WNAM
Bal permi Depa Impo		Mill	8/13	nund		100672	CR	EMATIC	N AN	FELLOW D FUNER D, ANNA	POL	CARI IS.J	MARYL	AND 2	1401
Physician		23a, Part I. Enter	the disease,	or complicate ns tha	at caused th	e death. Do	not enter th	ne mode of dyir	ng, such as	cardiac or respira	tory arres	t, shock,	or heart	Between	Onset and
Madical.		Immediate Cause	•	se on each line. se a. Heroin	and Et	thanol	Intoxic	ation_						D	Death
_xaminer		or condition resul			as a conseq	uence of):									
	7	Sequentially list of		b. Due to (or a	as a consec	uence of):									
	Examine	cause. Enter Und	buse. Enter Underlying Cause c. bisease or injury that initiated c. Due to (or as a consequence of):												-
ed	Exa														
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit	edical	X UNPENDE	D	AMENDE	D 23a.2	27.28a-	f per M	Œ g878 4	/4/08 a	amh					
50, nte be hysicia e buria		IF FEMALE:				e of pregnar		0				23d. E	Date of delive	,	
Box 68766 e death certificate the attending phy ed for use as the t	Physician/M	23b. Was deceder past 12 mont	nt pregnant ir ns?		ve birth	imp of doath		tal death	3 Ector	pic pregnancy		Mo	onth	Day	Year
OX (sici	1 Yes 2	No 9 🔲 l	Int name Time	regnant at ti nknown	me of death	5 Ot	her (Specify)							
by the	Phy	Part II. Other sig	nificant con	ditions contribution		but not resu	ılting in the u	underlying caus	se given in I					to the cause of	of death?
ords, P.O. Box 68766 aw requires that the death certificate has been signed by the attending phy 2 should be detached for use as the b	by			_						1	Yes	2 🗸 N	No 3 Pr		Unknown
ds, requir seen s	Completed			-						24	a. Was a		24b. Were prior to	autopsy findir o completion	ngs available of cause of
COF e law e has l	dm									1	perform		death? 1 ✓		2 No
R. The tiffcat tiffcat or, pag		25. Was case ref	erred to med	ical				26.PI	lace of Deat	th (Check only one	e)				
/ita /sician nis cer direct	o Be	examiner?	2 No	Hospital: 1	Inpatier	nt 2 E	R/Outpatien	t 3 DOA	Other ₄	Nursing Home			ce 6 🗹 Ott	ter: Scene	
of \ of Phy ig Phy ifer the	-	27. Manner of De		28a. [Date of Injur Month, Day,Ye	y 2 ear)	8b. Time of		Injury at Wo		escribe h	iow injury	y occurred		
on tendir eath. or: A	atio	1 Natural 2 Accident		ending FOU	nd 3/19	9/08 F	hd at 7	:30am	Yes 2	Ulk			151	Dural Davido	Number City
Part II. Other significant conditions contributing to death but not resulting in the uniderlying and the part of t										or	Town, S	tate) 1 7"	OO Ridge	ely St.	Number, City
Division Hospital or Attend 2 Hours after death Funeral Director: etely filled in by the 1	Certification:	4 Homicide	9								the caus		manner as s	tated.	
Division of Vital Records, P.O. B To the Hospital or Attending Physician: The law requires that the dowithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.		29a. Certifier (Check only one)	✓ Certifying ✓ Medical B	Physician: To the Examiner:On the ba	e best of my asis of exan	knowledge nination and	, death occu l/or investiga	ation, in my opi	nion, death	occurred at the tir	ne, date	and place	e, and due to	the cause(s))
To the within To the comple	Medical	29b. Signature a		anga_mani	ner s/ate/d.				cense numb					Month, Day,Y	
		/	1/	1	V			0	.C.M.E.			Marc	h 19, 200	8	
OCME		30. Name and ad	dress of per	so who completed	ause of de	eath (Item 2	3a)					1			
		Mary G. F		. Deputy Ch	ief Medic	al Exami	iner 11	1 Penn Str	eet, Balti	imore, MD 21	201				
	tate		onth, Day, Ye	2 4 2008	2. Registra	's Signature	H	han . V -							
Regis	tra	i	WAK	2 4 2008	- 4		W. A								
DHMH 17 Rev 1/2	2001						ORIGIÑA	AL							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Ma	i ylai		rtifica				•	Reg. N	2111118	10069	
	Physici	an	1. Decedent's Name (First, Middle, Las								2. Date of De Month		ayYear	3. Time of Death	
	/Medic			Kent W.	FEN	IDLER					March			9:30 P M	
	Examin	er	4a. Facility Name (If not institution, give 11801 Saddlerock				4b. City			on of Death Spring		4	c. County of Deat Montgor		
	Eumanal		5. Social Security Number 6. Se		(In yrs.	last birthday) If Und	or 1 Year		ler 24 Hrs.	R Date of Bir	th	9 Birth	holace (State or Foreign	
	Funeral Director			M 2□F		3 Yrs.	Months	Days	Hour	s Min.	Nov. 1	3, Yea	1924 Au	stria	
	D .		Usual Residence of Decedent 10a. State 10b. County		10c Ci	ty, Town or L	contine							10d. Inside City Limits	
	ahov	ō			100. 01			C	•					1 Tyes 2 No	
	28e-f	rect	Maryland Montgon 10e. Street and Number	iery		51	lver	Spr ip Code	ing			10a. C	citizen of What Co		
	3a or	Ω	11801 Saddlerock	Road				,	209	02		-	United S		
	deatl	nera	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U	J.S. 13.	Was Dec	edent of h	Hispanic	Origin? (Spe	ecify Yes or No Rican, etc.))-	14. Race - Ame Black, White		
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Items 23s or 28s-f ahow important: if Itam 27 is marked other than "natural", or Items 23s or 28s-f ahow any houry or other traumatic avant, Ita Micdical Examinar must be notified at ances.	by Funeral Director	1 ☐ Never Married	1/ Yes 2 No If Yes, Give Year or Dates:	° WW		1 🗆 Yes				, noan, etc.,			hite	
ģ	72 ho	Completed	15. Decedent's Ed (Specify only highest gra			16a. Dec	edent's Us	ual Occup	oation	nost of work	ina	16b.	Kind of Business/	Industry	
2	ithin ne.	mple	Elementary/Secondary (0-12)	College (1-4or 5-	+)					nost of work		11 4	C C C C C C C C C C C C C C C C C C C		
2	filed v Hygie other ti	S	17. Father's Name (First, Middle, Last)	5+		PE	erson	neii		gement	(First, Middle		S. Gover	nment	
and	d be f	Be c	Mark Fer	ndler							Tanne				
چ	should be I and Mental I s marked or urnatic ava	ဥ	19a. Informant's Name/Relationship (7			19b. Mai	ing Addre	s (Street	and Nun	n ber or Rura	al Route Numb	er, City	or Town, State, 2	Zip Code)	
Š	and 2 ealth a m 27 is		Regina Fendler, V	life		11801	Sad	dler	ock I	Road	Silver	Spi	cing, MD	20902	
ore	of He of He r oth		20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗆			Place of Disp	osition (Namatory or	ame of other pla	ce)		Date	20c.	Location - City or	Town, State	
Ĕ	Pages Iment of I Iant: If Its	,	4 ☐ Donation 5 ☐ Other (Specify)	Mt.	Lebar	ion C	emet	ery	03/16	5/08	A	delphi,	MD	
Baltimore, Maryland 21215-0036	Depart Import any In		21. Signature of Emer I Service Licen	Ser	5						uneral Wash			20012	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee												
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Coronary Artery Disease Years Due to (or as a consequence of):												
	Examiner				CONSEC	querice or).									
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consec	uence of):									
	icate be executed physician and s the buriat-translt	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с											
60,	be exician sourial	ai Ey	Due to (or as a consequence of):												
68760,	rificate be executed ng physician and as the burial-translt	le dicai	•	d											
Box		n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of			111						23d. Date of del	ivery	
	0 0	siciai	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown			□Ectopic □ Other (:		у				Month	Day Year	
о. О	at the de d by the a stached	Phys	9 Unknown												
Records,	The law requires that the ste has been signed by th page 2 should be detache	Completed by Physician/N	Part II. Other significant conditions on Multiple Chondro		t not res	sulting in the	underlying	cause gn	ven in Pa	ırt I.				o the cause of death?	
Ö	s been si should!	ojete									24a. Was			itopsy findings available	
	The lay	mo									auto perfo 1 ☐ Yes	psy ormed? 2√∐ N	death?	completion of cause of	
Vita		Be C	25. Was case referred to medical examiner?						26. Pla	ace of Death	Check only	-1		25.10	
o	d is	70	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatien	t 2	ER/Outpatie		Ot Ott	ner: 4 🗆	Nursing Ho	me 🛵 Resi	dence	6 □Other (Spec	cify)	
000	Stng After	ation;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year)	28b. Time Injury	of M	28c. Injui Wo 1 [ryat rk? Yes 2		28d. Describe	how in	ury occurred		
Division	in Street	Certification;	3 Suicide 6 Could not be determined	28e. Place of tnjur building, etc.			reet, facto	ry, office			28f. Location (City or To	Street a	and Number or Ru ite)	ural Route Number,	
_	pita ours ours ours filled		29a. Certifier 1 Certifying Phy	ysician: To the best of	f my kno	owiedge, dea	th occurre	d at the ti	me, date	and place,	and due to the	cause	s) and manner as	stated.	
	ha Hos in 24 h ha Fun pietely	Medicai	(Check only 2 Medical Examone)	iner: On the basis of and manner stat	examina	ation and/or i	nvestigatio	n, in my	opinion, o	death occurr	ed at the time,	date a	nd place, and due	to the cause(s)	
	To the within 2. To the complet	Σ	29b. Signature and title of contifier	// //			2	c. Licens		ər			ate signed (Monta		
á	0+1		· May K	beech				D 0	9834			Ма	rch 14,	ZUU8 	
~1	-11		30. Name and address of person who of Barry N. Rosenbau	um, M.D.,	ath (Iter 3720	n 23a) (Type) Farra	. Print) agut	Ave.	, 2n	d Floo	or, Ken	sin	gton, MD	20895	
	Sta Registr		31. Date filed (Month / DB), Year) 2	008 32. egistra	r's Signa	ature /	books	,							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amended items 7 & 20b State of Maryland / Department of Health and Mental Hygiene per Funeral Director; 03/12/2008 cs1 - State Registrar Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day **Physician** TAQUS 9:45 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner arro Kesville If Under 24 Hrs. If Under 1 Year 9. Birthplace (State or Foreign Country)

Maryland 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 5021 92 **Director** 0/5/1915 Usual Residence of Decedent filed within 72 hours after death with the Maryland a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🖍 No Director Carroll Eldersburg Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a iner must b 1442 Buckhorn Road 21784 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 12 Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bace - American Indian. Black, White, etc. 1 Yes 2 The If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 No Specify: White 3 Widowed 4 □ Divorced "natural", other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 0 Tire Company 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (Pages 1 and 2 should be f nent of Health and Mental I ant: If item 27 is marked of Rosella McAtee John Farrell ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine Green - Daughter 41 Pattison Avenue, Bloomington, Maryland, 21523 permit. Pages.

Department of He Important: If iter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State St. Josephs Catholic March 12. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Midland, Maryland 2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eichnorn-McKenzie Funeral Home P.A. 21. Signature of Funeral Service Licenses 8 East Main Street, Lonaconing, Maryland, 21539 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that cause. The death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, learning to infine rate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to for as a consequence offs The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the burial IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Dav 4☐Pregnant at time of death 5 ☐ Other (specify) as been signed by the a 2 should be detached f 9 Unknown 9 DUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 → No 3 □ Probably 4 □ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ Ho 24a. Was an has 1 autopsy performed completely filled in by the funeral director, page certificate l 1∏ Yes 2 1 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 | Yes 2 PNo 6 2 ER/Outpatient 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 3 DOA After this 27. Manne Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? (Month, Day Year) Injury 1 - atural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital 1 Crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mathematical examiner. 29a. Certifier Medical 29b. Signature and title of certifie 29c. License number illesw)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, 12 32. Registrar's Signature

Sulte

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

		For	State of I		d / Dep	delible Ink. artment of H <i>rtificate of I</i>	lealth and	Mental Hygi	ene	e.			
		- State Registrar	111		Ce	rtilicate of t	Death		g. No	8 10071			
Physici /Medic	_	Decedent's Name (First, Mide William	,	F. /		Frank		2. Date of Death Month	Day Y	ear ON LAA AM			
Examin		4a. Facility Name (If not instituti	ion, give street and numb	er)		4b. City, Town, or	Location of Deat	h	4c. County of I	Death			
		MANASUM Kega	OPI MEDINOL	Cen	U	34	1150119		Wirmico				
Funeral Director		5. Social Security Number 522-05-6497 Usual Residence of Decedent	6. Sex / 7. 1 M 2 □ F	Age (In yrs. I	last birthday, Yrs.	Months Days	If Under 24 Hrs Hours Min.		ay, Year) Country)				
/land		10a. State 10b. Coun	ity	10c. City	, Town or L	ocation				10d. Inside City Limits			
Many a-f sh	ţċ	MD Som	erset	Cr	isfiel	.d			1 □ Yes 2)(1)				
or 28	Director	10e. Street and Number				10f. Zip Code		10	10g. Citizen of What Country?				
th will		5010 Canal Dri	ve			2181	.7		USA				
r dea	Funeral	11. Marital Status	12. Was Decede Armed Force	es?	S. 13.	Was Decedent of H	ispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)		American Indian, White, etc.			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Fu	1 ☐ Never Married 2 ☐ Ma 3 ☑ Widowed 4 ☐ Divorce	If ∀e s. Give	□ No es:		1 ☐ Yes 2 No	Specify:	,	Specify:	White			
thou atura		21	ent's Education		16a. Dece	edent's Usual Occup	ation		16b. Kind of Busin	ness/Industry			
nin 72 In "na Medik	Completed		hest grade completed)	or 5+\	(Give	kind of work done of DO NOT use retired	during most of wo d)	orking		·			
d with giene r tha the f	E O	Elementary/Secondary (0-12)	5+	01 3+)	Pate	nt Agent			Priva	te			
e file al Hy othe vent,	Be C	17. Father's Name (First, Middle	le, Last)				18. Mother's Na	me (First, Middle, N	faiden Surname)				
uld b Menta	10 E	George Frederi	ick Frank				Bertha	wn					
2 sho and I is ma		19a. Informant's Name/Relation	nship (Type. Print)		19b. Mail	ing Address (Street	and Number or R	ural Route Number,	City or Town, Sta	ate, Zip Code)			
and and and n 27		Barbara Kueble	r - Personal			Canal Dr	ive, Cri						
of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	n 3 TRemoval from St	1 0	Place of Disp cemetery, cre	osition (Name of ematory or other plac	ce)	Date 2	20c. Location - Cit	ty or Town, State			
Pag ment ant: I		4 □ Donation 5 □ Other								n, Virginia			
permit. Depart Import any inj once,		21. Signature of Funeral Service	ce Licensee	20 h	2	22. Name and Addre	ss of Facility Bo	ounds Fund	eral Hom	e			
205 2	0 14	23a. Part1. Enter the disease, shock, or heart failure. Li	Heerry K	xap						y1and 21804 Approximate			
Medical Examiner be executed bhysician and stree burial-transit	edical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it is a list of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):											
The law requires that the death certificate by the has been signed by the attending physici age 2 should be detached for use as the bu	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ □ □ Unknown								of delivery n Day Year			
w requires that s been signed by should be deta	by	Part II. Other significant cond		th but not resu	ulting in the I	underlying cause giv	en in Part I.	23e. Did tob		ute to the cause of death?			
The law reate has bee page 2 sho	Completed							24a. Was ar autops perforn 1 Yes 2	y prid	ere autopsy findings available or to completion of cause of ath? Yes 22100			
y sician : Th is certificate director, pag	BeC	25. Was case referred to medie examiner?	cal	/			26. Place of De	eath (Check only on					
shysic this ce al direc	TO E	1 ☐ Yes 2 No	Hospital: 1 Inp	patient 2	ER/Outpatie	ent 3 DOA Oth	er: 4 Nursing	Home 5 ☐ Reside	ence 6 Other	(Specify)			
dlng F After funer	Certification:	3 Suicide 6 Coul	stigation Id not be 28e. Place of	Day Year)		Wor	yat k? Yes 2∐No			or Rural Route Number,			
the Hospital or Attenthin 24 hours after death the Funeral Director: mpletely filled in by the	edical Ce		ying Physician: To the b cal Examiner: On the bas and manne	is of examina									
To the within	F	29b. Signature and title of certification	Aur. T	-	MP	29c. Licens			- 7.	Month, Day, Year)			
Sta Registr		30. Name and address of personal states of personal	MATAPPA	of death (Item	1 B	Euslavn Fuslavn	Shore	m.	Salish	108 Jusy MD 2180			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ For	State of M							ental Hyg			10072		
_			1 - State Registrar			Cei	rtificate	of D	eath			Reg. No.	000	10076		
	Physici	an	Decedent's Name (First, Mice	idle, Last)							2, Date of Dea Month	ith Day	Yeer	3. Time of Death		
	/Media	cal	Betty Jane 4a. Fecility Name (If not institut	Gilmour			Ab Cib. T	Form	tion of		March		2008 County of Dea			
	Examin	er		Nursing Hom			4b. City, T	lkto		Death		Cecil				
	Funeral		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. last	birthday)	If Under 1	1 Year	If Under 2		8. Date of Birtl (Month, Day	Year	9. Bir	thplace (Stete or Foreign		
	Director		215-34-707	5 ^{1□ M 2} √√ F	83	Yrs.	Months	Days	Hours	Min.	3/22/			ton, MD		
	and w		Usuel Residence of Decedent 10a. State 10b. Coun	nty	10c. City, To	own or Lo	cation							10d. Inside City Limits		
	Many -1 sho	tor	MD Ce	cil	E11	kton	1							1 ☐ Yes ANO		
	or 28s	Director	10e. Street and Number				10f. Zip (Code		-		10g. Citiz	en of What C	ountry?		
	23a c		140 Danfor	d Drive				2192	21			U.S	.A.			
	er des	Funerai	11. Marital Status	12. Was Decedent Armed Forces	?	13.	Was Decede f Yes, speci	ent of His fly Cuban	panic Orig , Mexican,	in? (Spe Puerto i	cify Yes or No- Rican, etc.)	1	4. Race - Am Black, Whi			
36	irs aft	by F	1 ☐ Never Married 2 ☐ M. 3 ☐ Widowed 4 ☐ Divorc	If Yes Give A	-No		1□Yes 2	∀ X⁰	Specify:				Specify:	White		
Ö	be ilied within 72 hours after death with the Maryland ital Hygiene. Ind other than "natural", or itams 23a or 28a-f show event, the Medical Evairings must be notified at		15. Deced	ent's Education	10	6a. Deced	dent's Usual	Occupat	ion	and commendati		16b. Kin	d of Business	/Industry		
2	ithin 7	Completed	Elementary/Secondary (0-12	hest grade completed) 2) College (1-4or	5+)	life.	kind of work DO NOT use	e retired)	ining most	OF WORKII	ig					
72	Hygier Hygier ont, Inc		8th 17. Father's Name (First, Middl	lo Last)			Cle:	rk_	10 Mothor	r'a Nama	(First, Middle,		lestau	rant		
anc		Be c									_		surname)			
Maryland 21215-0036	s 1 and 2 should be I Health and Menta Itam 27 is marked other traumatic ev	ဥ	Ralph Geore 19a. Informant's Name/Relatio		1	9b. Mailir	ng Address	(Street ar			te Bli Route Numbe		Town, State,	Zip Code)		
	nd 2 lith a 27 is r tre		Nick Gilmon	ur, Son		140	Dan	ford	Dri	ive,	Elkto	on,	MD 21	921		
altimore,	of Head of Head of Itam or other		20a. Method of Disposition	n 3 Removal from State	come	of Dispo	sition (Name	e of			ate		ation - City or			
Ě	Pages Iment of tant: If it jury or o		* 4 Donation 5 □ Other	(Specify)			Ceme				3/2008	Che	sapea	ke City,MD		
Ba	permit. Pages Department of Important: If it any injury or one		21. Signature of Funeral Service	ce Licensee		D	ANIE	T C 0	TTTTO	DOTT	SON FU	JNER	AL HO	ME LLC		
Б		1	23a. Part1. Enter the disease,	ocomplications that cause	d the death. D	o not ent	12 N er the mode	. Br	oad	Str	reet, I	4idd	lletow	n, DE 1970!		
E	Physician		Immediate Cause (Final	ist only one cause on each li	ine.						, ,			Interval Between Onset and Death		
	/Medical		disease or condition resulting in death)		O RES		TORY	FAI	LURI	€						
	Examiner		Suquentially list conditions,	LEUKE	MIA											
	ed sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	- 01	a consequent	•	DW D									
	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	0.	RESPII		KI F	ATTC	JKE							
760	ysiciar e buri	cai		d. CAD												
89		ed	IF FEMALE:													
Box	death certifica e attending ph ed for use as th	lan/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Fetal dea	ath 3 🗆	Ectopic pre					2:	3d. Date of de Month	livery Day Year		
O	0 0 0	ysic	1 ☐ Yes _ 3/ 5/No 9 ☐ Unknown	4☐Pregnant a 9☐Unknown	t time of death	5	Other (spe	icify)								
a.	law requires that the as been signed by th 2 should be detache	by Physician/M	Part II. Other significant condi	itions contributing to death t	out not resulting	g in the ur	nderlying ca	use given	n in Part I.		23e. Did to	bacco us	e contribute t	o the cause of death?		
rds	w requires been sign should be	q pa	ANEMIA								1 □ Y	es 2]No 3□P	robably 4 Unknown		
Hecords,	law re as bee 2 sho	Completed	GERD								24a. Was a		24b. Were a	utopsy findings available completion of cause of		
	The ate h page	Com	HTN								perfor	med?	death?	s 2 No		
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medic examiner?					-		of Death	(Check only or	10)				
0	Phys this al dir	. To	1 Yes 2 No	Hospital: 1 Inpatio		Outpatien o. Time of	t 3 DOA	Other	4 W Nur		ne 5 🗌 Resid			ecify)		
0	th. : After funer	tlon	1 Natural 5 Pend		y Yeer)	Injury	M	Work?	os 2 □ N		.00. 20001100 11	OW III JULY	00001100	Î		
DIVISION	of or Attending after death. I Director: After din by the funer	Certification;	3 Suicide 6 Coul	mined 286. Place of in	jury - At home, tc. (Specify)	, farm, str	eet, factory,	office		2	28f. Location (S City or Tow		Number or A	lural Route Number,		
5	ital or irs afte rel Die led in	Cer		Ballourig, or	ic. (Specify)						Ony of 1011	Olaloj				
	To the Hospital within 24 hours a To the Funerel Completely filled	Medical	29a. Certifier 1 Certify (Check only one) 2 Medic	ying Physician: To the best al Examiner: On the basis of	of examination	dge, death and/or inv	occurred a restigation, i	t the time in my opii	, date and nion, death	place, a	and due to the ded at the time, o	ause(s) a date and p	and manner a place, and du	s stated. e to the cause(s)		
	o the ithin 2 o the omple	Med	29b. Signature and title of certif	and manner st	ated.		29c.	License	number			29d. Date	signed (Mon	th, Dey, Year)		
	F ≤ F ŏ		· La	Ol. A			C	1-00	0501	2			1/08			
		4	30. Name and address of person	on who completed cause of o	death (Item 23a	а) (Туре,	Print)									
-			MUHAMMED A.	NIAZ, 266	S. CC	LLE	GE AV	7F:	NEW	ARK	DE 14	711				
	Sta Registr		31. Date filed (Month, Day, Yea	ar) 32. Registr	Signature	le de	A AV	ر صد - صد				• •				
uk,	riegisti	4.1	1140	0	- AMERICAN	S	100									

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryl	•	artment of F rtificate of a		- '	giene Reg. No.	8 (10073
37	a a	П	1. Decedent's Name (First, Middle, Las	,				2. Date of Dea		Year	3. Time of Death
	Physicia /Medic			rett H.	Guest			March	14 20	80	16:15 PM
	Examin	er	4a. Facility Name (If not institution, give 845 Red Toad Ro			North	r Location of Death	1	4c. County of		
	Funeral	_	5. Social Security Number 6. S	ex 7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	h	9. Birthpl	ace (State or Foreign
9 ,-2	Director		222-16-8422 Usual Residence of Decedent	XXM 2□F 78	Yrs.			March 2		DeT	aware
	yland how at		10a. State 10b. County	10c.	City, Town or Lo	ecation				10	d. Inside City Limits
	ne Mai Ba-f si otifled	Director	Maryland Cecil		North E						1 □ Yes 2 No
	with the		10e. Street and Number 845 Red Toad Ro	a d		10f. Zip Code			10g. Citizen of W		
	death	Funeral	11. Marital Status	12. Was Decedent Ever i	n U.S. 13.	21901 Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S	pecify Yes or No-	United 14. Race	S CA C - America k, White, e	an Indian,
30	be filed within 72 hours after death with the Maryland ntal Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Forces? 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		1 ☐ Yes 2 No	Specify:	o riiouri, etc.)		.Whit	
5-0036	2 hour atural		15. Decedent's Ed	lucation	16a. Dece	dent's Usual Occup	pation		16b. Kind of Bu	siness/Ind	ustry
212	within 7; iene. than "n. the Medi	Completed	(Specify only highest gra	College (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of wor d)	king			
12.0	filed with Hygier ther ther ther ther ther there	Co	12 17. Father's Name (<i>First, Middle, Last</i>)	1	1	ineman	18. Mother's Nan	ne (First. Middle.	Teleph Maiden Surnam		Company
land	lid be flental liked of	To Be	Homer Guest					Miller		-,	
lary	ges 1 and 2 should it of Health and Men If item 27 is marke or other traumatic	_	19a. Informant's Name/Relationship (19b. Mailir	ng Address (Street	and Number or Ru	ıral Route Numbe	er, City or Town,	State, Zip	Code)
e (•	1 and 1 ealth ealth 27 ther tr		Charles Mars / Fr		120 F	Red Toad	Road, No	rth East	Mary1a		
	Pages nent of h int: If ite		1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specific	In 14 00 1	cemetery, crei	matory or other place Creek rian Ceme	Hai	ch		•	,
aitimor	permit. Pag Department Important: any injury c		21. Signature of Funeral Price Ucer	nse	resbyte	rian Ceme 2. Name and Addre	stery 19	. 2008 Crouch F	Wilming uneral	ton. Iome	Delaware
מ	a limit		Hell Co							, Mar	y1and21901
			23a. Part1. Enter the disease, of com shock, or heart failure. List only Immediate Cause (Final	plications that caused the cone cause on each line.	leath. Do not ent	ter the mode of dyir	ng, such as cardiad	/ N			Approximate Interval Between Opset and Death
1	Physician /Medical	П	disease or condition resulting in death)	a. Due to (or as a con	sequence of):	Esopha	aged 1	Conce		-	2 12 46215
	Examiner		Sequentially list conditions,	b	,	200	0.50				
- 4	ed sit	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	Day to (or as a con	sequence of):					3	
,	execut n and al-trar	Examiner	that initiated events resulting in death) Last	c Due to (or as a con	sequence of):						
08/00	ficate be executed physician and sthe burial-transit	edical		_d						\perp	
		Med	IF FEMALE:	23c. If yes, outcome pf pre	agnanov						
DOX	death certif e attending d for use as	ician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death 3	□Ectopic pregnanc	/		Mor	e of delive nth	ny Day Year
5	that the ed by the detached	Physic	9 ☐ Unknown	9□Unknown							
l S	w requires that the d been signed by the should be detached	by	Part II. Other significant conditions of	ontributing to death but not	resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	/		e cause of death? ably 4 Unknown
ecords	law requas been 2 should	Completed						24a. Was	an 24b. V	Nere autor	osy findings available
T	The la	omp						autor	osy prmed?	orior to con death?	npletion of cause of 2□ No
N I Cal	ysician: The law Is certificate has b director, page 2 s	Be C	25. Was case referred to medical examiner?			- lau		ath (Check only o			
20	Phy this	2	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatier 28b. Time o		4 ☐ Nursing F		dence 6 Other		/)
VISION	Attending Frdeath. ector: After by the funera	ation	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea		Wor	k? Yes 2∐No				
	or Attendi ter death. irector: A n by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - A building, etc. (Sp	At home, farm, str	reet, factory, office		28f. Location (8 City or Tox	Street and Number vn, State)	er or Rura	l Route Number,
ב	pital cours af	Cel	29a, Certifier 1 Certifying Ph	ysician: To the best of my	knowledge deat	h occurred at the ti	me date and place	and due to the	cause(s) and ma	nner as si	ated
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	ledical		niner: On the basis of examend manner stated.							
	Vithi Vorus	M	29b. Signature and title of certifier	00-1		29c. Licens	e number	\	29d. Date signed	(Month,	Pay, Year)
			raren Z	antel ,	Man Can T	Drint)	01000	,	100/	'//	2008
1	0+1VA			MD, 20 C	12 g am	Road-S	Suite 106	, Part	Deposit	-, M)	D 21904
3	Sta Registr		31. Date filed (Month, Day, Year)	2008 32. Redistrar's S	ignature	hours					
					-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month '2 Physician 5-SUZalo -/3 Autonio D. A-M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 8. Date of Birth (Month, Day, Year)
March 2, 1 If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2 □ F 263-25-6954 80 Director 1928 Cuba Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 □Yes 2 No Director Maryland Prince George's Beltsville 10e Street and Number 10f. Zip Code 10g Citizen of What Country? 6001 Ammendale Road 20705 USA Funeral . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1X Never Married 2 Married Yes 2 No Cuban White Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages in the Department of Health and Mentan. If Item 27 is marked other the any Injury or other traumatic event, the 5+ Teacher Religious Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leon Gonzalez Velez Maria Teresa De La Torre 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John McErlean, FSC/Superior 6001 Ammendale Road, Beltsville, MD 20705 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ★ Burial 2 Cremation 3 Removal from State March 15, De La Salle Cemetery Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** cumona disease or condition resulting in death) /Medical monary disease Examiner Cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2□ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 20 To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 27. Man of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturai (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide

P.O. Box 68760 Division or Vital Records,

with the Maryland

death v

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

28a-f show

23a or

5

'natural",

Examiner must be notified at

The law requires that the death certificate be executed ohysician has e 2 r this certificate has ral director, page 2 or Attending Physician: Atter 24 hours after death.
Funeral Director: A etely filled in by the fu To the Hospital o within 24 hours aff To the Funeral D completely

Medical Certification:

6 Could not be determined 4 Homicide

(Check only one)

31. Date filed (Monta

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certified

29d. Date signed (Month, Day, Year)

30. Name and address of who completed cause of death (Item 23a) (Type, Print) cunina

32. Restrar's Signature

State

State of Maryland / Department of Health and Mental Hygiene 0 0 8

Physician Modical Examiner Pink Modical Examiner			•	For State Registrar		Ce	rtificate of	Death		R	leg. No.		
Maud B. Gill Street Street Financial Street Street					it)				2.			Year	3. Time of Death
Formation Final Street Service (See Septial 1) Final Street Service				Maud B. Gill						March			6:45 a ^M
Source Part of the Part Part of the				4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location	of Death		4c. Cour	ity of Death	
Director Control Cont								-		Data of Birth			
Color Colo		Funeral		1	□M 2187F				Min.	(Month, Day	', Year)	Coul	ntry)
10. Carry 10.	h	Director		086-30-2747					F	eb. 21	., 1919	j Bu	rilla
John Buchana		and t			10c. Cit	y, Town or L	ocation					-	I0d. Inside City Limits
John Buchana		f sho	ò	Marziland	Montgomery		Silver S	Sprine	T				1 ☐ Yes 2 ☑ No
John Buchana		the 28a-	rec		Horregomery								ntry?
John Buchana		3a or		15301 Beaverb	cook Court, Ap	t. 3K			2090	6	τ	JSA	
John Buchana		ms 2	ner	11. Marital Status	12. Was Decedent Ever in U	S. 13.	Was Decedent of H	lispanic Or	igin? (Specify	/ Yes or No- an, etc.)	14. F		
John Buchana	0	after or Ite		_	1 ☐ Yes 2√☐ No					,			
John Buchana	3	ural".			Year or Dates:	10- 0	danta Hayal Oscur	nation					
John Buchana	5	"natu	lete	15. Decedent's Ed (Specify only highest gra	ucation de co <i>mpleted)</i>	(Give	kind of work done	during mos	at of working		TOD. KING O	Dusinesa/iii	ddairy
John Buchana	4	within	dm	Elementary/Secondary (0-12)				-/			Own	Ноте	
John Buchana	7	Hygid Hygid ther int, th		17. Father's Name (First, Middle, Last)		11011	iciia kei	18. Moth	er's Name (F	irst, Middle,			
23a Part Erber the disease, or complications that fauled the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.	0	d be) B	John Buchanan				Maria	a Pete	rs			
23a Part Erber the disease, or complications that fauled the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.		shoul nd Me marl marti	Ě	19a. Informant's Name/Relationship (Type. Print)	19b. Mail	ing Address (Street	and Numb	er or Rural R	Route Numbe	er, City or Tov	vn, State, Zij	Code)
23a Part Erber the disease, or complications that fauled the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.	Ž	nd 2 alth a 27 is rr trai		Thomas W. Gill/Hu	ısband	1530	1 Beaver	orook	Court	, Silv	er Spi	sing,	MD 20906
23a Part Erber the disease, or complications that fauled the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.	נ נ	s 1 a		·	20b. F	Place of Disp cemetery, cre	osition (Name of ematory or other pla	ce)	Marc	h 14,	20c. Locatio	n - City or T	own, State
23a Part Erber the disease, or correlications that faulted the doubt. Do not enter the mode of dying, such as cardiac or respiratory arrest.	2	Page Hent of	/			etropo	litan Cr	emato	ry 20	08	Alexar	ndria,	Virginia
23a Part Erber the disease, or correlications that faulted the doubt. Do not enter the mode of dying, such as cardiac or respiratory arrest.	<u> </u>	partin porta y inju		21. Signature of Funeral Service Licer	nsee	É	2 Name and Addre	ess of Facili	ins F	uneral	Home	Inc.	
Physician //Medical Examiner Physician //Medical Examiner //Me	۵_	89 = 89		2 conto	Jobles							Spring	
Physician (Middled Examiner) Framinger Sequence of program Sequ				23a. Part1. En er the disease, or com shock, or heart failure. List only	plications that caused the deat one cause on each line.	h. Do not er	ter the mode of dyi	ng, such as	cardiac or re	espiratory ar	rest,		Interval Between
Sequentially list conditions, large legislation of the large legislatio		Physician		disease or condition	a Cardiopulmon	ary Ar	rest						
State State State Sequentially list conditions, ill anyl, legaling to immediate cause of death of the past 12 months? Due to (or as a consequence of): Due to (or as a cons				resulting in death)	Due to (or as a conseq	uence of):							
February Part Company Part Com		Examine	_	Sequentially list conditions,			omatosis						
FEMALE: 23b. Was decedent pregnant 1 23c. It yes, outcome pf pregnancy 1 23c. It yes outcome pf pregnancy 1 23c. It		ed sit	ine	if any, leading to immediate cause. Enter Underlying	Due to tor as a conseq	derice oi).							
FEMALE: 23b. Was decedent pregnant 1 23c. It yes, outcome pf pregnancy 1 23c. It yes outcome pf pregnancy 1 23c. It	_	and and II-tran	хап	that initiated events resulting in death) Last	c	uence of):							
FeMALE 23b. Was decedent pregnant in the past 12 months? 1 Lives 2 No 9 Unknown 23d. Date of delivery Month Day Year 1 Lives 2 No 9 Unknown 2 Lives 2 No 1 Lives 2 No 2 Lives 2	5	be e			4								
FeMALE 23b. Was decedent pregnant in the past 12 months? 1 Lives 2 No 9 Unknown 23d. Date of delivery Month Day Year 1 Lives 2 No 9 Unknown 2 Lives 2 No 1 Lives 2 No 2 Lives 2	000	icate phys s the	edic		0								
25. Was case referred to medical examiner? 1	3	certii nding use a					□=				23d.	Date of deliv	very
25. Was case referred to medical examiner? 1	Ď	death atte	icia	in the past 12 months?	4□Pregnant at time of o							Month	Day Year
25. Was case referred to medical examiner? 1	į	t the	hys	9 ☐ Unknown									
25. Was case referred to medical examiner? 1	'n	ss tha		Part II. Other significant conditions of	ontributing to death but not res	ulting in the	underlying cause gi	ven in Part	l.				
25. Was case referred to medical examiner? 1	2	en sig								10	res 2∐ No		bably 4 XUNKNOWN
25. Was case referred to medical examiner? 1	נו נו	law re as be 2 sho	plet							autor	osy	prior to co	opsy findings available ompletion of cause of
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smitha Bhikkaji, MD 1500 Forest Glen Road, Silver Spring, MD 20910 State 31. Date filed (Month, Pay, Year) 32. Bygistrar's Signature		The ate ha	mo;										2□No
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smitha Bhikkaji, MD 1500 Forest Glen Road, Silver Spring, MD 20910 State 31. Date filed (Month, Pay, Year) 32. Bygistrar's Signature	2	slan: ertifica ctor.							e of Death (0	Check only o	ne)		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smitha Bhikkaji, MD 1500 Forest Glen Road, Silver Spring, MD 20910 State 31. Date filed (Month, Pay, Year) 32. Bygistrar's Signature		hysic his ca al dire		1 ☐ Yes 2 ☐ No	1 Mainpatient 2 L		SILL SEL DOA	4 LI N					ífy)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smitha Bhikkaji, MD 1500 Forest Glen Road, Silver Spring, MD 20910 State 31. Date filed (Month, Pay, Year) 32. Bygistrar's Signature	_	Ing P		1 Natural 5 ☐ Pending	(Month, Day Year)					a. Describe i	now injury oc	surred	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smitha Bhikkaji, MD 1500 Forest Glen Road, Silver Spring, MD 20910 State 31. Date filed (Month, Pay, Year) 32. Bygistrar's Signature	2	tend leath. tor: /	cati	3 Suicide 6 Could not be		ome farm s				Location (S	Street and Nu	ımber or Ru	ral Route Number.
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smitha Bhikkaji, MD 1500 Forest Glen Road, Silver Spring, MD 20910 State 31. Date filed (Month, Pay, Year) 32. Bygistrar's Signature	\leq	or Al	ıtifi		building, etc. (Speci	fy)	aroot, idotory, omoo			City or Tox	vn, State)		,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smitha Bhikkaji, MD 1500 Forest Glen Road, Silver Spring, MD 20910 State 31. Date filed (Month, Pay, Year) 32. Bygistrar's Signature	_	spital		29a. Certifier 1 ☐ Certifying Ph	nysician: To the best of my kn	owledge, dea	ath occurred at the t	time, date a	and place, an	d due to the	cause(s) and	manner as	stated.
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smitha Bhikkaji, MD 1500 Forest Glen Road, Silver Spring, MD 20910 State 31. Date filed (Month, Pay, Year) 32. Bygistrar's Signature		e Hos 24 h e Fur letely	dice	(Check only 2 Medical Exam	niner: On the basis of examination	ation and/or	investigation, in my	opinion, de	eath occurred	at the time,	date and pla	ce, and due	to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smitha Bhikkaji, MD 1500 Forest Glen Road, Silver Spring, MD 20910 State 31. Date filed (Month, Pay, Year) 32. Bygistrar's Signature		To th Within To th	Me	29b. Signature and title of certifier			29c. Licen						
Smitha Bhikkaji, MD 1500 Forest Glen Road, Silver Spring, MD 20910 State 31. Date filed (Month, Day, Year) 32. Project aris Signature		_) Sat The	,			D641	00		Marc	n 13,	2008
State 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature		5		30. Name and address of person who									
							en Road,	Silv	er Spr	ing, N	4D 209	T0	
				31. Date filed (Month, Day, Year) MAR 1 4 2	100		Parks -						

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Marion Virginia Greenwood 2008 March 14, 2:18P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Ye Feb. 18, Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Year) 1921 Months 87 1 M 2 X 1 Feb. Director 577-20-8855 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show "natural", or items 23a or 28a-f shovedical Examiner must be notifled at 1 ☐ Yes 2X No Montgomery Director Maryland Clarksburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12216 Dancrest Drive 20871 Funeral U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. 1 ☐ Yes 2 █️No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify White Specify: δ 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'any Injury or other traumatic event, the Me Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Chester Hutchinson Addie Holliday 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Alan Greenwood - Son 12216 Dancrest Drive, Clarksburg, Maryland 20871 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 ☐Removal from State Parklawn Memorial Park 03/19/08 4 □ Donation 5 Other (Specify) Rockville, Maryland 21. Signature of Funeral Service Licensee Molesworth-Williams P.A., Funeral Home west 26401 Ridge Road, Damascus, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive Heart Failure /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4⊡Pregnant at time of death 5 Other (specify) P.O. I signed by the a d be detached for 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Tes 2 No 3 Probably 4 Unknown been si should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform certificate 2**X** No Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 ☐Xinpatient ျှ 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: (Month, Day Year) Injury 1 Xatura! 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 24 hours a CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 66189 March 15, 2008

State Registrar 30. Name and address of person who complete

31. Date filed (Month, Day, Year)

Andrew Meenaskshi

MAR 1

9901 Medical Center Drive, Rockville, Maryland

cause of death (Item 23a) (Type, Print)

M.D.

2008

32. Registra Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 03 **Physician** RED 06 1 NE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□ M 2 F 80 Director 1927 Washington, DC 577-30-0820 Dec. 28, Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1X Yes 2 No Director Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16010 Excalibur Road D208 20716 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 2 1 ☐ Yes 2X No Specify: 3 XWidowed 4 ☐ Divorced Specify: White Completed of Health and Mental Hygiene. item 27 is marked other than "natul other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Francis Aloysius Myers ျှ Rose Mary Fugazzi 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven A. Gainey/ Son 215 Jefferson Avenue Charles Town, WV 25414 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven
Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 3/12/2008 |Silver Spring, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician DURICI zmon disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria IF FEMALE 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day signed by the a 5 Other (specify) 9 Unknown Part II. Other significant conditions/contributing to death/but not resulting in the underlying cause given in Part II. 23e. Did tobacco use contribute to the cause of death? by 2 Ho 1 Yes 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of After this certificate has funeral director, page 2: autopsy death? 1 ☐ Yes 2 ☐ No perforn 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl ne Hospital: 1 Yes 2 → No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 12 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Stratural (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō Hospital AGertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manger stated. (Check only 29b Signature and title of Certifier 29c. License number 2 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

(CAMEL Jila

31. Date filed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

W

32.

gistrar's Signature

Division or Vital Records, P.O. Box 68760,

28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1: Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 29a, Certifier 🙀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number D0057600 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OAIC BOWN MD 22911 Seffer Block In the bury MD 21783 31. Date filed (Month, Day, Year)

State Registrar

Medical

32. Registrar's Signature

VOID

CERTIFICATE

2008-10079

SEE

CERTIFICATE #

2008-10794

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No... 3. Time of Death 2. Date of Death Day 2008 Decedent's Name (First, Middle, Last) 8:37 p M **Physician** March 11, Henry Faucile /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Silver Spring Holy Cross Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days Hours 1 ☐ M 2 🖫 F 1923 Haiti 577-11-6813 May 15, 84 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County "natural", or items 23a or 28a-f show sdical Examiner must be notified at 1 □Yes 2√ No Director Silver Spring Montgomery Maryland 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number filed within 72 hours after death with Hygiene. Haiti 20906 12802 Teaberry Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ ★o if Yes, Give Year or Dates: 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black Baltimore, Maryland 21215-0036 2 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) event, the Medical than, Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic event, once. Be Regina Cineus Dufort Henry 2 19a. Informant's Name/Relationship (Type. Print) -Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Jose Lauredan Bonhomme 12802 Teaberry Road, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition March 14 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 4 □ Donation 5 □ Other (Specify) 2008 Silver Spring, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc 500 University Blvd., W. Silver Spr Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Respiratory Failure /Medical Due to (or as a consequence of): Examiner Aspiration Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examin Alzheimer's Disease The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): P.O. Box 68760 attending physician for use as the buria Debility Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 ☐ Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 Yes 2 No 3 Probably 4 Nound been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 212 No certificate has be irector, page 2 s 1□ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner Other: Hospital: 1 ☐ Yes 21 No 2 X ER/Outpatient 3 □ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient P 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification:

Division or Vital or Attending Physician: After this certification after death. within 24 hours aft

To the Funeral Di

completely filled in To the Hospital

5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No M 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 ☐ Suicide 4 Homicide 1 Scrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one) 29b. Signature and title of certif

31. Date filed (Month APR: Year)

29c. License numbe

D41624

29d. Date signed (Month, Day, Year) 08

eted cause of death (Item 23a) (Type, Print) 30. Name and address of person who com MD Patrick Murphy,

1500 Forest Glen Road, Silver Spring, MD 20910

State Registrar

Medical

32. egistrar's Signature 2008

and manner stated



Fur Dire

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Physi /Me Exam

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the attending about and

Division or Vital Records, P.O. Box 68760,

	1	For State Registrar		Ce	ertificate of	Death	Re	g. No. 2	300	100	8
ysicia	n	1. Decedent's Name (First, Middle, La John	P.		Hathaway		2. Date of Death March	Î2,	2Ŏ8	3. Time of Dea 10:00A.	
Medica amine		4a. Facility Name (If not institution, gi	ive street and number)		4b. City, Town,	or Location of Deatl	h	4c. Coun	ty of Death		
amme		Heritage Harbour Hea	lth and Rehabi	ilitation	Annapo				Arun		
eral ctor			Sex 7. Age 1X M 2 F	78 Yrs.	Months Days		8. Date of Birth (Month, Day, NOV 22,	1929	Coui	olace (State or Fo otry) Sachuset	
10/00/	-	Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or I	Location					10d. Inside City L	.imits
tified at	Director	Maryland Anne Ar		Riva				0:4:	5 talls at Coun	1 □ Yes 2 [No
ist be no	al Dire	10e. Street and Number 213 Grisdəle Hil	1		10f. Zip Code 211	40	10		ted Si	tates	
хаш	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 1 Yes 2 □ N If Yes, Give Year or Dates I	Everin U.S. 13 No ean Conflict	77	Hispanic Origin? (Sban, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		ace - Americ lack, White, cify: Wh	etc.	
lcal	eted	15. Decedent's I (Specify only highest g	Education trade completed)	16a. Dec	cedent's Usual Occ ve kind of work don	upation e during most of wo red)	rking	16b. Kind of	Business/In	dustry	
the Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+) Labor						opping C	ərts
event,	Be	17. Father's Name (First, Middle, Las Adiel Hathaway	st)				_{me (First, Middle, M} hittaker	Maiden Surn	ame)		
aumatic	ဂ္	19a. Informant's Name/Relationship				et and Number or R				o Code)	
her tr	-	Brenda J. Turk - 20a. Method of Disposition	daugnter	20h Place of Dis	nosition (Name of	Hill Riv		20c. Location		own, State	
D'or of	,	1 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Control Cont		Parklawr	rematory or other p n Memoria	l Park 3/	17/2008	Rockv	ille,		d
any Inj once.		21. Signature of Funeral Service Lic	Persee	V	Bons 1 d v 4400 Powe	resBorgward ler Mill I	dt Funera Road Belt	1 Home sville	e, PA e, Mar	yland 20	0 7 05
		23a. Part1. Enter the disease, or co shock, or heart failure. List on	emplications that caused	the death. Do not e						Approximate Interval Between	en
cian		Immediate Cause (Final disease or condition	Нурох	_						Onset and Dea	ath
lical		resulting in death)	a	a consequence of):							
iner	-0	Sequentially list conditions,	bb.	a consequence of):			· · · · · · · · · · · · · · · · · · ·	-			
ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	с			**					
as the burial-transit		resulting in death) Last	Due to (or as	a consequence of):							
	Medical	IF FEMALE:						-			
ed for use	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	23c. If yes, outcome 1 ☐Live birth 4 ☐Pregnant a 9 ☐ Unknown	2 Fetal death	3 □Ectopic pregna 5 □ Other (s <i>pe</i> cify)				Date of deli- Month	very Day Yea	ar
etach	Phy	9 ☐ Unknown Part II. Other significant conditions		ut not resulting in the	underlying cause	niven in Part I	23e. Did to	bacco use c	ontribute to	the cause of dea	ath?
nd be d	Completed by	Congestive Heart	_			giron in racti.	1 □ Y			v	
2 shot	plete	Cardiomyopathy					24a. Was a	an 24	b. Were au	topsy findings ava	ailable se of
page	Com						perfor 1□ Yes	med? 2 ZNO	death? 1 ∐ Yes	2X No	
ctor,	Be (25. Was case referred to medical examiner?	11-2-2-1				eath (Check only or				
al dire	2	1 ☐ Yes 2 No	Hospital: 1 Inpati		TIETT SI DOA		Home 5 ☐ Resid			cify)	
funera	ion	27. Manner of Death 12 Natural 5 ☐ Pending 3 ☐ Accident investigat	28a. Date of Inju (Month, Da	ury 28b. Time ny Yea <i>r</i>) lnjui		njury at vork? □ Yes 2 □ No	28d. Describe fi	ow injury oc	curred		
in by the	Certification:	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	t be 28e. Place of in	ury - At home, farm, tc. (Specify)			28f. Location (S City or Tow	treet and Nu n, State)	ımber or Ru	ral Route Numbe	9 <i>r</i> ,
completely filled in by the funeral director, page 2 should be detached for use	Medical Ce	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best xaminer: On the basis of and manner st	of examination and/o	eath occurred at the r investigation, in n	e time, date and pla ny opinion, death oc	ce, and due to the c curred at the time,	cause(s) and date and pla	d manner as ice, and due	stated. to the cause(s)	
dEoc	Me	29b. Signature and title of certifie			29c. Lice	ense number		29d. Date si	gned (Montl	h, Day, Year)	
) (h	Head	Ou		1897		March 12, 2008			
ļ		30. Name and address of person wi				^ E11 4+	+ Ci+ N	farul c	nd 210)/12	
C.	to	Njide Udochi, M	32. Pa dist	Yevrolet L rar's Signature	rive,#IU	O ETITIOE	t Olly, P	101 A 191	110 210	J+4	
Sta egistr		31. Date filed (Month, Day, Year) MAR 14		yes de	frank)						

Registrar

Type of I fill black		•
State of Maryland / De	epartment of Health a	ind Mental Hygiene

2		0	8	Br. 1 - 1 - 1 - 1	0	0	8	2
Same	Section	March	1000		100			

NK UNK	1-3	State of Maryland / Department of For State Certificate of		Reg. No	200	0 10002
	Re	Decedent's Name (First, Middle Last)	2. Dat	te of Death	Year	3. Time of Death
Physician Physician Examine	21	AUCESTER HOPPS	Ma	onth Day rch 10, 200	8	1245 hrs
	48	a. Facility Name (if not institution, give street and number) 4	b. City, Town, or Location of Death		 County of Death Montgomery 	
		12109 Bluhill Road	Silver Spring		•	hplace (State or Foreign
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs. 8. D Months Days Hours Min.	T / 7	1939 CO	untry) EORGIA
Director		219-34-9342 1/M 2DF 68 Yrs.		uly,	111 0	LUKUITI
any	_	Sual Residence of Decedent 10c. City, Town or Locati	on			10d. Inside City Limits
*		MD. MONTGOMERY WHEAT	ON			1 Yes 2 No
4aryland 28a-f show		Oe Street and Number	10f. Zip Code	10g. C	itizen of What Cou	
or 28	Ulrector	12109 BLUHILL ROAD	20902		V. S. A	
with t		1. Marital Status 12. Was Decedent Ever in U.S. 13. Was	as Decedent of Hispanic Origin? (Specify es, specify Cuban, Mexican, Puerto Ricar	Yes or No- n, etc.)	14. Race - Amer White, etc.	ican Indian, Black,
death or iter	Funeral	1 Never Married 2 Married 1 Yes 2 No	Yes 2 No specify:		Specify: BL	ACK
after ral",	>	or Dates:	nt's Usual Occupation (Give kind of work d	done 16b	. Kind of Business	
hour hour	<u>ا</u> ۾	College (1-4 or 5+)	nost of working life. DO NOT use retired)		FLOORI	NG
136 hin 72 e. than edical	ompleted	12 TH FLOOR	RING CONTRACT	OR		
5-06 ed with	٦١	17. Father's Name (First, Middle, Last)	18.Mother's Name (Firs	st, Middle, Maid	en Surname)	
21215-0036 21215-0036 Jude filed within 72 hours after from the filed within 72 hours after marked other than "natural", ic event, the Medical Examiner.	8	Edward Hopps 19a. Informant's Name/Relationship (Type, Print) 19b. Mailin	Theofis g Address (Street and Number or Rural	Route Number	City or Town, Stat	e, Zip Code) 7 0 6 0 1
	₽ 1	KEITH A. HOPPS (SON) 1504	# 2 TRUMAN MANO sition (Name of cemetery, Da	OR LAN	E Wald	or F, Md.
M 2 m 2 m 2 m 2 m 2 m 2 m 2 m 2 m 2 m 2	1 2	20a. Method of Disposition 20b. Place of Dispo	sition (Name of cemetery, Da	ite 20	c. Location - City o	r Town, State
iore ges 1 it of H it If ii	П	1 Burial 2 Cremation 3 Removal from State	ther place) BURG CREM. MARG	24,08	SMITHSBI	1R6, MD.
Baltimore, permit. Pages I an Department of He Important: If ite		21 Signature of Funeral Service Licensee 22.	Name and Address of Facility / A.A.	, 1 R1	716/15/	FUN. ITOME
Ba Perm Depu	Ť	bung. Collin	IN WEST SOUTH ST	PREDE	EICH P	Approximate Interval
Physician	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. Un only one cause on each line.	the mode of dying, such as cardiac or res	spiratory arrest,	snock, or near	Between Onset and Death
/Medical		Immediate Cause (Final disease a Atherosclerotic cardiovasc	ular disease			2,5,1
		or condition resulting in death) Due to (or as a consequence of):				
	er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	Εl	cause. Enter Underlying Cause (Disease or injury that initiated (Disease or injury that initiated Due to (or as a consequence of):				
nted d ansit	ŭ	events resulting in death) Last d.				
te be executed tysician and burial - transit	edical	▼ UNPENDED	3 4/2/08 amh			
760, cate be		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 F	Fetal death 3 Ectopic pregnancy	,	23d. Date of deliv	ery Day Year
30x 6876 Jeath certificate e attending phy for use as the	ä	nast 12 months?	Fetal death 3Ectopic pregnancy Other (Specify)		*	
Box 6876 e death certificat the attending ph	Physician/N	1 Yes 2 No 9 Unknown g Unknown		Didtaha	and the contribute	to the cause of death?
O. I at the d by the stacke		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.			robably 4 Unknown
ires that the signed by d be detacled	g p			24a. Was an	24b. Were	autopsy findings available
ords w requals been should	plet			autopsy perform	ed? death	
Recorthe la cate ha	Completed by	li .		1 ✓ Yes 2	No 1 🗸	Yes 2 No
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial – transi	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatie	26.Place of Death (Check online and 3 DOA Other Nursing H		esidence 6 🗸 O	ther: Scene
F Vit	유	1 ✓ Yes 2 No Impatient 2 Literapate	,		w injury occurred	
ding h. Afte	<u>ö</u>	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of	1 Yes 2 No			
isio Atter er deat by th	cat	2 Accident Investigation 28e. Place of Injury - At home, farm, st	reet, factory, office building, etc. 28	8f. Location (Str or Town, Sta		Rural Route Number, City
Div after Div	ertif	determined (Specify)				
Hosp 24 hos Fune stely fi	<u>a</u>	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death oc (Check only one) 2 Medical Examiner: On the basis of examination and/or investigated	curred at the time, date and place, and du	ue to the cause he time, date ar	s) and manner as	stated. o the cause(s)
Division of Vital Records, P.O. Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that th within 24 hours after death. To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detach	Medical Certification:	one) 2 Medical Examiner: On the basis of examination and/of investigation and manner stated.	29c. License number	1	29d. Date signed	(Month, Day, Year)
	ž	29b Signature and title of certifier	O.C.M.E.		March 11, 200	
		(I antistell)				
3		37. Name of address of person who come cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Pe	nn Street, Baltimore, MD 2120	1		
	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	P W.			
Regis			554 <u>C</u>			
DHMH 17 Rev 1/2	2001	OCME	NAL			

			For State	State o	of Maryland		artment of H		l Mental H	yglene	108	10083
	_		Registrar			Cer	tificate of E	Jeath	O Data of F	Reg. No.	100	To Fine of Death
	Physicia	en an	Decedent's Name (First, Middle, I RUTH MISSK	•	HEWATT				2. Date of E Month	Day	Year	3. Time of Death
	/Medic						4h Oir Tour	Landing of Da	MARCH	12	2008 ty of Death	00:13A M
	Examin	er	4a. Facility Name (If not institution, g			-1	4b. City, Town, or	ville	am			
gpe.	All the second s		Shady Grove A 5. Social Security Number 6.	Sex	7. Age (In yrs. I		If Under 1 Year		rs. 8. Date of E	Birth	ntgome 9. Birth	pplace (State or Foreign
	Funeral Director		157-16-3214	1□ M 2 X F	83	Yrs.	Months Days	Hours Mi	in. (Month, L	Day, Year) 15 1924	Cot	w Jersey
deli	St		Usual Residence of Decedent						Dec.	13 1324	IVEV	w bersey
	yland now at		10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
	Mar-f st	ż	Md. Mont	gomery		Lay	tonsville					1 ☐ Yes 2 🔀 No
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citizen o		·
	th wil	a	8011 Warfield	Road				20882		Unit	ed St	tates
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hydiene. Important: If learn 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Fo		S. 13.\	Was Decedent of His f Yes, specify Cuba	spanic Origin? n, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	No- 14. R B	ace - Amer lack, White	ncan Indian, e, etc.
0030	ours aff	by	3 ☐ Widowed 4 ☑ Divorced	If Yes, Gi Year or D	ve		1 □ Yes 2 M No	Specify:		Spec	ify: Wh	nite
<u> </u>	72 ho	Completed	15. Decedent's (Specify only highest of	Education		16a. Deced	dent's Usual Occupa	ation Juring most of v	vorkina	16b. Kind of	Business/I	ndustry
7	thin 7	ple	Elementary/Secondary (0-12)	College (kind of work done d OO NOT use retired,			1		
7	er th	S	12	2		Admi	nistrativ					e Company
BUE	be filk	Be	17. Father's Name (First, Middle, La Richmond Mi	st) sskelly				18. Mother's N	lame (First, Midd Sa Lup		ame)	
Ž	d Mer narke	2	19a. Informant's Name/Relationship			10h Mailie	ng Address (Street a				ın Stata 7	(in Codo)
<u>0</u>	ud 2 sl ulth an 27 is r r traur		Cynthia H. West		ghter		1 Warfiel					20882
Ç.	of Hea		20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3	C Domewal from		lace of Dispo emetery, crer	sition (Name of natory or other place	θ)	Date	20c. Location	1 - City or	Town, State
Dailimo	Page ment ant: If ury o		4 □ Donation 5 □ Other (Spe		Me		itan Crem		/13/08		ındria	a, Virginia
200	permit. Depart Import any in once.		21. Signature of Funeral Service Lic	ensee	- 1	22	Name and Addres Muriel H					
	40 = 60 OI		Moug	12	ann		P. O. B				Md.	
	73		23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that only one cause on o	each line.	n. Do not ent	-1		liac or respiratory	arrest,		Approximate Interval Between Onset and Death
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	sept	TC	Shoul	<u> </u>				1 day
	Examiner			Due to	(or as consequ	uence of):	700 D	11011	In Oil	n		1 day
	15.	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a consequ	uence of):	IUVI 1	nevi	mou			<i>y</i> Gody
	cuted id ansit	Examiner	ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c.			'					
Š	e exectan ar		resulting in death) Last	Due to	(or as a consequ	uence of):						***
0/00	cate be executed hysician and the burial-transit	dical		d								
Ď K	ertific ling p	Me	IF FEMALE:	000 16 100 01	teems of present							
S	ath c	ian/	23b. Was decedent pregnant in the past 12 months?	1□Live	itcome pf pregna birth 2 ☐ Fetal	Ideath 3	Ectopic pregnancy				Date of deli Month	ivery Day Year
5	The law requires that the death certificate be executed tee has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Me	1 ☐ Yes 2 No 9 ☐ Unknown	9□Unkr	nant at time of de nown	eath 5L	Other (specify)			-		
ŗ	that led by deta		Part II. Other significant condition	s contributing to a	leath but not resu	ulting in the u	nderlying cause give	en in Part I.	23e. Di	d tobacco use co	ontribute to	the cause of death?
Solds	uires sign ld be	Completed by	Dysphagi	α , Ω	arki	nsa	- Dise	2558	1[Yes 2 No	3 □ Pr	obably 4 □Unknown
2	w req	ete	1 in of	while	Ac:	200	`			as an 24	b. Were au	itopsy findings available
ב ב	he lay b has ge 2	mp	C-1212	WACIC		0051			– au	topsy rformed?	prior to death?	completion of cause of
ō	n: Ti ficate rr, pa		OCITS					00 BL 15	1 Yes		1 ☐ Yes	2 14 0
5	sicia certi recto	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	¶npatient 2 □	EB/Outnotion	nt 3 DOA Othe	or.	Death (Check onl			-16 A
5	Phy r this ral di	2	27. Manner of Death	28a. Date	of Injury	ER/Outpatier 28b. Time o			g Home 5 ☐ Re 28d. Describ	e how injury occ		city)
5	ding th. : Afte : fune	tion	Natural 5 ☐ Pending 2 ☐ Accident investigat		nth, Day Year)	Injury		(? Yes 2∐No				
2	Atter r deal ector by the	ifica	3 Suicide 6 Could not	t be 28e. Place	e of injury - At ho	me, farm, str	eet, factory, office			(Street and Nu. Town, State)	mber or Ru	ural Route Number,
5	tal or	Certification:	4 Homicide	build	ang, etc. (Specin)	// 			City of I	own, State)		
	Hospi 24 hour Funer tely fill	edical		caminer: On the t	basis of examina		h occurred at the tim vestigation, in my o					
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Med	29b. Signature and title of certifier	and mar	nner stated.		29c. License		·	29d. Date sig		
			M//n	1		MI	D.C.	-365	4	Marc	412	,2008 He MD2085
			30. Name and address of person wi	no completed cau	se of death (Item	23a) (Type,	Print)		*			
	8		VADNAO	2411)	990	1/1	edical	Ceut	er Dri	ve, Ro	ckest	Le MD2085
1	Sta	te	31. Date filed (Month, Day, Year)		Registre Signa	ture	Accell 1					
	Registr	ar	MAR	1 7 2008	A Malanta	2 10	STATE OF THE PARTY					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

			1 - For State Registrar	Oldie of Maryland		ertificate of l		wienianny	Reg. No.	2008	10084
	Physicia	an	1. Decedent's Name (First, Middle, La	st)				2. Date of De	eath Day	Year	3. Time of Death
	/Medic		Robert J. Hell					March	9, 2	2008	3:15 P M
	Examin	er	4a. Facility Name (If not institution, giv			4b. City, Town, or		ı		County of Deat	
Mary	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. la	ast birthd		Landing If Under 24 Hrs.	8. Date of Bi	rth	nne Aru	hplace (State or Foreign untry)
ii.	Director		399-50-0360 Usual Residence of Decedent	Xim 2□F 62	Yrs	Months Dave	Hours Min.	(Month, Da 4/19/	1945	Wis	consin
	yland now at		10a. State 10b. County	10c. City	Town or	Location					10d. Inside City Limits
	e Mar a-fsh tifled	ctor	Maryland Anne Ar	ınde1	Tra	cys Landin	g				1 ☐ Yes 2 🛣 No
	or 28	Dire	10e. Street and Number			10f. Zip Code			_	en of What Co	ountry?
	s 23a	Funeral Directo	6645 Chesapeake			2077		- 17 N	USA	4. Race - Ame	sia an Indian
	ter de item	Fun	11. Marital Status1 Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 🛣 No	.	 Was Decedent of Hi If Yes, specify Cuba 	an, Mexican, Puert	o Rican, etc.)	0-	Black, White	
200	urs af al", or Exam	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 X No	Specify:			Specify:	White
215-0036	be filed within 72 hours after death with the Maryland Hylylene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest gra	ducation ade completed)	(G	ecedent's Usual Occupative kind of work done of	during most of wor	king	16b. Kin	d of Business/	Industry
12	vithin ene. than "	mp	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		e. DO NOT use retired	0 -		١.,	D., 1, 1	
7	filed v Hygie other t	ပ္ပ	17. Father's Name (First, Middle, Last		WI	iter	18. Mother's Nan	ne (First, Middle		Publica Surname)	itions
Maryland	ld be tental ked or	To Be	Hugo	Hellman			Marg	garet So	cheun	ge1	
ar∖	shou and M s mar	٦	19a. Informant's Name/Relationship (Type. Print)	19b. M	ailing Address (Street a	and Number or Ru	ral Route Numb	per, City or	Town, State, 2	Zip Code)
Σ.	and 2 ealth in 27 I		Alice Sturm/ Daug			8 29th Str					
ore	ges 1 t of H If iter or oth		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐	Hemoval from State		sposition (Name of crematory or other plac		Date	20c. Loc	cation - City or	Town, State
baltimore,	t. Partmen rtmen rtant: njury		4 Donation 5 Dother (Special	Kal	as C	rematory		r\08		ewater,	
g	permit. Pages 1 and 2 should be f Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic even once.		21. Signature of Furning Souther Lio		2	22. Name and Address 2973 Solom		-			
			23a. Part1. Enter the disease, or com	plications that caused the death	. Do not					ater, I	Annroximate
	Physician		shock, or heart failure. List only Immediate Cause (Final	Inanition							Interval Between Onset and Death 3 months
	/Medical		disease or condition resulting in death)	aDue to (or as a consequ							J months
	Examiner		Sequentially list conditions.	_{b.} Valvular							9 months
	ed sit	ine	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ						0	0.1
	execut al-tran	Examiner	that initiated events resulting in death) Last	c		rcinoid Tu	mor				2+ years_
68/60,	rificate be executed g physician and as the burial-transit			_d							
Q	rtificat ng phy as th	Medi	IE EEMALE.						1		
o D	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregnar	death	3 ☐ Ectopic pregnancy			2:	3d. Date of del Month	ivery Day Year
	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of de 9□Unknown	ath	5 ☐ Other (specify)				· · ·	bay tour
Τ.	requires that the een signed by th nould be detache		Part II. Other significant conditions	ontributing to death but not resu	Iting in the	e underlying cause give	en in Part I.	23e. Did	tobacco us	se contribute to	the cause of death?
coras,	quires n sign uld be	d by						1 🗆	Yes 2□]No 3∏Pr	robably 4 □Unknown
ဝပ္ပ	law re as bee 2 shor	Completed						24a. Was		24b. Were au	utopsy findings available completion of cause of
Ì	The late ha	mo:						auto perf 1⊟ Yes	ormed? 2 X No	death?	·
VITAI	cian: ertific ector,	Be (25. Was case referred to medical examiner?	114-1-		I ou	26. Place of Dea				
0	ding Physician: The lav n. Affer this certificate has funeral director, page 2 s	P.	1 ☐ Yes 2 X No 27. Manner of Death	Hospital: 1 Inpatient 2 E	R/Outpa 28b. Tim	tient 3 DOA Othe	4 ⊔ Nursing H	ome 5 X Res 28d. Describe			cify)
	Attending r death. ector: After by the funer	tion	1 XNatural 5 Pending 2 Accident investigation	(Month, Day Year)	Injui	ry Worl	Yes 2 □ No	200. Describe	now injury	occurred	
IVISION	l or Attend after death. Director: /	ifica	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of injury - At hor building, etc. (Specify	ne, farm,	street, factory, office		28f. Location	(Street and	Number or Ru	ural Route Number,
5	tal or rs afte al Dir ed in	Certification	4 _ Hornidae	building, etc. (Specify	,			City of To	wn, State)		
	To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one) 1. ☐ Certifying Photos 2 ☐ Medical Example 1. ☐ Medical Exa	nysician: To the best of my know niner: On the basis of examinat and manner stated.	vledge, de ion and/o	eath occurred at the tin r investigation, in my o	ne, date and place pinion, death occu	, and due to the rred at the time	e cause(s) , date and	and manner as place, and due	s stated. e to the cause(s)
	Vithii To th	M	29b. Signature and title of certifier			29c. License	e number		29d. Date	signed (Mont	h, Day, Year)
				Wern	5000	1	15123		Marc	ch 11,	2008
7ر	412		30. Name and address of person who James Ahlgren, MI	2150 Pennsy			Washin	ton DC	2 000	227	
	Sta	te	31. Date filed (Month, Day, Year) MAR 1 3	32. Restrar's Signat	ure		_ wasiiing	con, DC	200	13/	
	Registr	ar		- Alleger	S.	Soule					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Physician Burris Frederick Husman 7:45 P^M MARCH 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death **Examiner** Berlin Nursing Home Berlin Worcester If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 10/6/1919 6. Sex 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) Days Country) XXM 2□ F 329-14-0320 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2√ No Director Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21060 USA 101 Ralph Rd. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 TYPes 2 □ No WWII 1 ☐ Never Married 2 ☐ Married White If Yes, Give Year or Dates: 1 ☐ Yes XXNo Specify. δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Professor University 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mintie Sanders Henry Husman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 2 Cambridge Place Ocean Pines, MD 21811 Fred Husman 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/13/2008 Md Veterans Cemetery Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 21. Signature of Funeral Sexice Dicensee 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an arrest line. Immediate Cause (Final disease or condition resulting in death) a consequence of) Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy BE No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ို 1 🔲 Inpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Matural

sician and burial-tran Division or Vital Records, P.O. Box 68760, attending p To the Hospital or Attending Physician: the funeral director. 24 hours a

Funeral

Director

show

ms 23a or 28a-f shov must be notified at

an "natural", or Items Medical Examiner mu

S

or other t

Health a

permit. Page Department o Important: If any Injury or

Physician

/Medical

Examiner

with the Maryland

death

Pages 1 and 2 should be filed within 72 hours after

SMAN, HARRIS

Certification: 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day,

32, Registrar's Signature

person who completed cause of death (Item 23a) (Type, Print)

1209

DHMH 17 Rev 1/2001

Hyling Franck Island De 18940

State

Registrar

DHMH 17 Rev 1/2001

29h. Signature and title of certifier

31. Date filed (Month. Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008 3

no Za 32 Registrar's Signature 29c. License number

29d. Date signed (Month, Day, Year)

Greenway Center Dr. Green beit, MD 20770

Matthew John Hall 08-00975

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 | 0087

NK ONK	1- For State Control of Death Reg. No. Registrar Certificate of Death Registrar	
Physician/	1. Decedent's Name (First, Middle,Last) Month Day	3. Time of Death
ি া Examiner	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	4c. County of Death
	6901 Oxon Hill Road	Prince George's M/DD/YYYY) 9. Birthplace (State or
Funeral Director	213 15 4921 1 Mm 2 F 34 Yrs. Months Days Hours Min. Feb 6, 19	Foreign Washington
v any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits 1 Yes 2 No
Aaryland 1 at once	Maryland Charles Port Tobacco 10e. Street and Number 10f. Zip Code 10g. C	Citizen of What Country?
th the Maryland 23a or 28a-f sho	7457 Howard Drive 20677 Uni	ited States
72 hours after death with the Maryland 72 hours after death with the Maryland all Examiner must be notified at once leted by Funeral Director		14. Race - American Indian, Black, White, etc.
s after de	> 3 Widowed 4 Divorced or Dates:	Specify: White b. Kind of Business/Industry
hours a		5. Kind of Business/industry
nore, MD 21215-0036 siges I and 2 should be filed within 72 hours after not of Health and Mental Hygiene. 1: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner To Be Completed by	Elementary/Secondary (0-12) College (1-4 or 5+) Bartender	Restaurant
21215-0036 July be filed within 72 Mental Hygiene. marked other than 'cevent, the Medical To Be Complet		ien Surname)
21215 21215 Duld be file I Mental H I marked (It event, t	John Hall JoAnn Mattia Joann Mattia 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number)	, City or Town, State, Zip Code)
MD 2 Id 2 shou lith and M m 27 is n aumatic	JoAnn Bush (Mother) 7457 Howard Drive, Port Tobacc	co, MD 20677
re, MC s 1 and 2 sl of Health at If item 27	20a. Method of Disposition 1 MBurial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Mar 15, 2008	Oc. Location - City or Town, State
트 링 힐 등 등	4 Donation 5 Other Specify: Resurrection Cemetery C:	linton MD
Balti permit. Departm Importa	Alexandria Ferry Road C	Home, Inc 6633 Uld
- Physician	2 a. art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,	shock, or heart Approximate Interval Between Onset and
Vledical xaminer	fallure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	Death
	Sequentially list conditions, b. b. Due to (or as a consequence of):	
	The same of Enter Underlying Cause	
ted I Insit	Cisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.	
execuian and ial - tra	X UNPENDED AMENDED 23a, 27, 28a-f per ME g877 3/28/08 amh IF FEMALE: 23c. If yes, outcome of pregnancy	
760, cate be physici	IF FEMALE: 23b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 butus after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	past 12 months? 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	
O. En at the day the day the stacked		acco use contribute to the cause of death? 2 No 3 Probably 4 Unknown
J. P. Lires th	<u> </u>	24b. Were autopsy findings available
ords aw requ as beer 2 shoul	autopsy perform	prior to completion of cause of death?
Rec The Is	24a. Was an autopsy perform 1 V Yes 2 26. Place of Death (Check only one)	No 1 Yes 2 No
ital sician: s certil	© 25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other Nursing Home 5 Re	esidence 6 🗸 Other: Scene
of V		w injury occurred
Sion vttendin death. ctor: A y the fu	Notini, Day, 1 early Notini, Day, 1 early	reet and Number or Rural Route Number, City
lor At after d Direct	28e. Place of Injury - At home, farm, street, factory, office building, etc. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 27e. Location (3) or Town, Sta Oxon Hill.	ate) 6901 Oxon Hill Road
C Hospital 1.24 hours e Finneral		(s) and manner as stated. nd place, and due to the cause(s)
To the within To the comple		29d. Date signed (Month, Day, Year)
		February 4, 2008
-	30. Name and address of person who completed cause of death (Item 23a)	
1	Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
Sta	ate 31. Date filed (Month Ray Year) 7 2008 32. Raistran's Signature	CME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 000 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2127P M GEORGE CLIFTON JONES 10, 2008 MAR /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner KENT CHESTER RIVER HOSPITAL CENTER CHESTERTOWN If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 XM 2 ☐ F Director 3/18/1932 MD 220-30-0239 Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director WORTON KENT MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a or Examiner must be r USA 21678 10745 WORTON RD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ▼ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify þ Specify: WHITE 3 Widowed 4 Divorced Item 27 is marked other than "natural", other traumatic event, the Medical Exa Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TRANSPORTATION TRUCK DRIVER 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) es 1 and 2 should be fill of Health and Mental H fitem 27 is marked oth Be ROBERT PAUL JONES, SR. ROSABELL HURTT ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELIZABETH A. JONES/WIFE 10745 WORTON RD. WORTON, MD 21678 permit. Pages 1 a
Department of Hes
Important: If Item
any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHURCH HILL, MD CHURCH HILL CEMETERY 3/15/08 21. Signature of Funeral Service License 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME Kick A. 130 SPEER RD. CHESTERTOWN, MD 21620 23a. Part1. Enter the disease, or confolications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician days Sepons /Medical Due to (or as a onsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or a jury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transi Due to (or as a consequence of): P.O. Box 68760. attending physician certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month 5 Other (specify) ☐Yes 2☐No the detached 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ρ 3UTI SIDDM. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed arterial Disease DHW ORF 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? Yes 2 No Old CVA (DCOP) certificate rector, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death. To the Funeral Director; After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide the Hospital 1 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Millem, M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) +

State

Registrar

hostertown

K. Wun 415 Washington

MAR 1 2 2008 >

32. Registra s Signature

31. Date filed (Month, Day, Year)

			1 - For Stete Registrar	State of M	aryland / Dep <i>Ce</i>	artment of rtificate of		and Mental Hy	/giene Reg. No.	008	10089
			1. Decedent's Name (First, Middle, Las	(1)				2. Date of D Month	eath Day	Year	3. Time of Death
	Physici /Medio		William James J	ohnston				March	19.		12:00 A ^M
	Examir		4a. Facility Name (If not institution, give	street and number;		4b. City, Town,	, or Location of	of Death	4c.	County of Death	
			12620 St. Patric			Little	Orlean			legany	-1 (Ohte Ferrier
П	Funeral		5. Social Security Number 6. S	9X 7.A(7.A(7.A(ge (In yrs. last birthday, Yrs.	Months Day		Min. (Month, D	ay, Year)	Cou	place (State or Foreign ntry)
	Director		160-20-9111 2 Usual Residence of Decedent		80 113.			July 18	1921	PA	
	yland		10a. State 10b. County		10c. City, Town or Li	ocation					10d. Inside City Limits
	B Mar	ctor	MD Allegany		Little Or	leans					1 ☐ Yes 2X No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citiz	zen of What Cou	ntry?
	ath w	ra	12620 St. Patric		5	2176		2 (2	USA	14. Race - Ameri	ago Indian
	ter de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces: 1 ∑Yes 2 □		If Yes, specify Cu	i Hispanic Ori iban, Mexicar	gin? (Specify Yes or N n, Puerto Rican, etc.)	0-	Black, White,	
39	or, or	by	3 ☐ Widowed 4 🔂 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ N	o Specify:			Specify: Wh	ite
Maryland 21215-0036	72 hours after death with the Maryland neturel', or Items 23e or 28e-1 ehow digal Evar il ar must be rodiffed at		15. Decedent's Ed		16a. Dece	dent's Usual Occ	upation	t of working	16b. Kir	nd of Business/Ir	ndustry
21	within 7 ene. than "r	Completed	(Specify only highest gra	College (1-4or	life.	DO NOT use retii	red)	Car Working			
21	filed wi Hygien other th	Con	12	···	Wel	der	40.14-11-	de Norma (Circh Adidd)		el Manuf	acture
and	be fil d oth	Be	17. Father's Name (First, Middle, Last)					er's Name (First, Middle	e, Maiden	Sumame)	
ž	2 should be n and Mental 1s marked c reumatic ev	2	William Johnson 19a. Informant's Name/Relationship (1)		19h Maili	ng Address (Street		rah Rheem or or Rural Route Numi	her City or	Town State Zi	p Code)
Ma	d 2 si th an th an treut		William H. Johnsto					nsville, M			0 0000)
	ges 1 and 2 should be filed within 72 hours after death with the Marylan at of Health and Mental Hygiene. If item 27 is marked other than "neturel; or items 23e or 28e-f ehow or other treumatic event, the Medical Exactinet must be profilled at		20a. Method of Disposition	A17 DO11	20b. Place of Disp			Date		cation - City or T	own, State
JOE TO	Pages nent of ont: If it iry or o		1 ☐ Burial 2√☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	Removal from State	Smithsbu	ra Crema	tory 0	3/20/2008	Smith	sbura.	MD
Baltimore,	± 문 번 등 .		21 Signature of Funeral Service Lice	A		2. Name and Add				n Stree	
ä	Depa Impo any i		1 Kal	I'Ve ~	G	rove Fun	eral H	ome, P.A.			
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that cause one cause on pach I	d the death. Do not en						Approximate Interval Between
L	Pnysician	8 11	Immediate Cause (Final disease or condition	Yest	Istatic Co	incer;	Drima	ry unknown			Onset and Death
Н	/Medical Examiner	- 1	resulting in death)	Due to (or as	a consequence of):	,	1	7	•		
	LAdimine	_	Sequentially list conditions,	b. —	a a sia sia sia an						
	led Isit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	а сопъециенсе об.						
	axecu and al-tra	Examine	that initiated events resulting in death) Last	Due to (or as	a consequence of):						
8760,	icate be executed physician and s the burial-transit			d							
9	tificat ng ph) as th	fedical									
Вох	ires that the death certific signed by the attending p d be detached for use as i	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		⊒Ectopic pregnan	ncy		2	23d. Date of deliv	very Day Year
	e dea the at ned fo	Sicl	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□ Unknown	t time of death 5[Other (specify)				WOTET	Day 16a.
P.O.	The law requires that the ste has been signed by the bage 2 should be detache	P.	Part II. Other significant conditions of	ontributing to death I	out not resulting in the u	inderlying cause (niven in Part I	23e. Did	tobacco u	se contribute to	the cause of death?
ds,	signe d be d	1 by	Zitti. Othor significant conditions	Shall bearing to death i	out not resulting in the t	inderlying cadse (giveri ii i ait i		Yes 2		bably 4 Unknown
Ö	w require been si should	ete						24a. Wa	s an	24h Were aut	opsy findings available
Rec	has ge 2	Completed						aut	opsy formed?	prior to co	ompletion of cause of
a	n: Th		25. Was case referred to medical				OR Place	1 ☐ Yes of Death (Check only	2 No	1 🗆 Yes	2 LI No
₹	s certi	To Be	examiner?	Hospital: 1 Inpati	ent 2 ER/Outpatie	nt 3 DOA)thor			3 ☐Other (Spec	ify)
ō	g Phy er thi		27. Manner of Death	28a. Date of Inj (Month, Da		f 28c. In		28d. Describe			
Ö	Vttendin death. ctor: Aft y the fun	atlo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		ty reer/ Injury		Yes 2	No .			
Division of Vital Records,	l or Atte after de Directo	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	286. Place of in	jury - At home, farm, st tc. (Specify)	reet, factory, offic	е		(Street and own, State,		ral Route Number,
	ital o										
	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	edical			of my knowledge, deat of examination and/or in						
	o the ithin (o the emple	Med	29b. Signature and title of certifier	and manner s	aidu.	29c. Lice	nse number		29d. Dat	e signed (Month	, Day, Year)
	⊢≯⊢ŏ		Mathe LL	hn Mi		D56	048		March	119, 2008	7
			30. Name and address of person who	completed cause of	death (Item 23a) (Type	,	00 1	4		,	
			Matthew Hahn 13	o West H	ا اسم ا	ancock,	1 Vangle	and 217	50		
	Sta		31. Date filed (Month, Day, Year)	32. Regist	ar's Signature	8					
	Registr	ar	MAR 2 8 2008	DEAGNED .	A STATE OF THE STA						

			For State Registrar		State of I	Marylan	•	artment of F rtificate of a	lealth and N Death	•	giene _{Reg. No.} 2 (06	10090
	Dhysisi		1. Decedent's Name (First,	Middle, La	ıst)			, .		2. Date of De Month	ath Day	Year	3. Time of Death
ş	Physici /Medio			Jack						March	18.	2008	2040 ^M
	Examir	er	4a. Facility Name (If not ins	titution, giv	e street and numb	er)		4b. City, Town, or	r Location of Death			ty of Death	
			Washington 5. Social Security Number			Hospi Age (In yrs. I		Takon If Under 1 Year	na Park If Under 24 Hrs.	8. Date of Bir	Mont	gome 9. Birtho	ry lace (State or Foreign
	Funeral Director		428-74-397		1 x M 2□ F	7	1 Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da	y, Year) •1936	Coun	itry)
	D		Usual Residence of Decede	ent						INOV.O	, 1930	MS	
	arylar show dat	_	10a. State 10b. C	,		10c. City	, Town or Lo					1	0d. Inside City Limits 1 Yes 2 No
	he Ma 8a-f	Director	Md.	PG			Hyat	tsville	<u> </u>		40 0'''	(1415-4-0	
	with t	ä	10e. Street and Number	٠	Dood			10f. Zip Code	705		10g. Citizen o		
	ns 23	Funeral	7869 Burns	тае	12. Was Decede	ent Ever in U.	S. 13.		1785 Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No	- 14. Ra	ace - Americ	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2页 3 ☐ Widowed 4 ☐ Div	-	Armed Force 1 ☐ Yes 2 If Yes, Give Year or Date	No		lf Yes, specify Cuba 1 □ Yes 2 ☑ 100 No		Rican, etc.)	Spec	ack, White, ify: Bla	
20	72 ho natur lical	Completed	15. De	cedent's E	ducation ade completed)		16a. Dece	dent's Usual Occup	eation during most of work	rina	16b. Kind of		
2	ithin ne.	nple	Elementary/Secondary (0		College (1-4	or 5+)	life.	DO NOT use retired	during most of work d)	g			
2	lled w tygiel her tl nt, th		1.2 17. Father's Name (First, M	liddla Lasi	*1		Carp	enter He	elper 18. Mother's Nam	o /First Middle	Gover		<u>-</u>
and	d be f ental H ed of) Be			,					, ,		zirie)	
2	shoul nd Me mark imati	욘	Albert Jac 19a. Informant's Name/Rel				19b. Mailir	ng Address (Street	Salma and Number or Rui	Will: al Route Numb		n, State, Zip	Code)
Z	1 and 2 Health a tem 27 Is		Gloria Jac	ksor	n/wife		786	Burnsi	ide Road	[0.70 E	-	•	
ore,	es 1 a of Her item	j	20a. Method of Disposition			20b. P	lace of Dispo	sition (Name of natory or other place	ide Road P, Md. 2	bate Date	20c. Location	- City or To	own, State
<u><u>Ĕ</u></u>	Pages ment of I ant: If ite ury or of		1 ☑ Burial 2 ☐ Crem 4 ☐ Donation 5 ☐ Ot			110	. Nat	ional C	em. 3/26	1/08	Laure	1. Md	3.
Baltimore, Maryland	permit. Departi Importi any Inj once.		21. Signature of Funeral S	ervice Lice	nsee// /		22	2. Name and Addre	ss of Facility Hoo	dges &	Edwar	ds F	.н.
	20 E 8 9		youns	10	None	_			ver Hil			and.	
ļ.			23a. Part. Enter the disea shock, or heart failure	se, or com List only	one cause on eac	sed the death h line.	n. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_	a		egs.	15					
	Examiner		,	- (Due to (or	as a consequ	ience **):	1.1.					
		ē	Sequentially list conditions		b. Due to for	as a conse	jence o :	14-1-1					
	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	1	c								
oʻ	e exectant		resulting in death) Last	R	Due to (or	as a consequ	uence of):						
68760,	tificate be executed ig physician and as the burial-transit	edical			d	<u>-</u>							
_	ertific		IF FEMALE:		02a If was auton	— me mé progra	DO1						
Box	The law requires that the death cert to has been signed by the attending to be 2 should be detached for use.	Physician/M	23b. Was decedent pregna in the past 12 months			me prpregna n 2∐Fetal tattime ofde	ldeath 3	Ectopic pregnancy Other (specify)	y		I	ate of delive Nonth	ery Day Year
o.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9☐ Unknow		eau JL						
σ.	s that ned b	by Pt	Part II. Other significant co	onditions	contributing to deat	h but not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did 1	obacco use co	ntribute to th	ne cause of death?
Records,	quire; en sig uíd be	q pe	Znd	1 10	ge p	MA	(7	Cille	\sim	1 🗆	Yes 2□ No	3☐ Prob	pably 4 Unknown
ဝ	aw re	pleti					/			24a. Was		. Were auto	psy findings available
ž		Completed			_					auto perfo 1∐ Yes	ormed?	death?	mpletion of cause of 2☐₩0
Vita	cian: ertific ctor,	Be	25. Was case referred to mexaminer?	edical					26. Place of Deat	h (Check only o	one)		
2	this o	P	1 Yes 2 No		Hospital: Inp		ER/Outpatien		4 LI Nursing Ho				y)
E	ding F	ion:		ending		njury Day Year)	28b. Time of Injury	Wor	yat k? Yes 2 □ No	28d. Describe	how injury occi	urred	
Division or	or Attending Physician: after death. Director: After this certifica in by the funeral director, p	ficat	3 Suicide 6 □	ould not b	e 28e. Place of	injury - At ho	me, farm, str	eet, factory, office	Tes ZENO	28f. Location (Street and Nur	nber or Rura	al Route Number,
2	i i te	Certification:	4 ☐ Homicide	letermined	building	etc. (Specify	1)			City or To	wn, State)		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	ledical C	29a. Certifier 1 Ce (Check only one) 2 Me	rtifying Pl dical Exa	hysician: To the be miner: On the basi and manner	s of examinat	wledge, deatl tion and/or in	n occurred at the tirvestigation, in my o	me, date and place, opinion, death occur	and due to the red at the time,	cause(s) and i	manner as s e, and due to	tated. the cause(s)
	To th Withir Comp	Me	29b. Signature end title of o	ertifier	1101	0), 0	Q (29c. Licens	e number		29d. Date sign	ned (Month,	Day, Year)
					10.50	fue	5)14	1 14	5474		3/	19/	2008
		ļ	30. Name and address of p	erson who	completed cause of	of death (Item	23a) (Type,	Print)	C	1	CI	7 -	
	- 01		31. Date filed (Month, Day,	Year)	9 83 Ref	istrar's Signat	m.J	/ [[[]	M	ng	JT-5	He a	+244,
	Sta Registr		MAR 2	8 200	/	J. J.	A SOM	E)		/			1

DHMH 17 Rev 1/2001

ORIGINAL

DK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** TIMOTHY MARK KAYLOR 13,2008 04AM March /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Saint Center BALTIMORE Medical OWSOR JUSEPH If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** Hours Months Days 1 XM 2 ☐ F Director 6/16/1958 018-50-3250 MA Usual Residence of Decedent 10c, City, Town or Location 10a, State 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2**X** No CHESTERTOWN Director MD KENT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21620 10355 BUNTING RD. USA 2 should be filed within 72 hours after death and Mental Hygiene.
Is marked other than "natural", or Items 23s Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 【 No Specify. þ 3 Widowed 4 Divorced WHITE Completed Madical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) th. LABORER CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be t and 2 should be fi Health and Mental H THOMAS KAYLOR SYLVIA HANSCOME 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra ALISON KAYLOR/WIFE 10355 BUNTING RD. CHESTERTOWN, MD 21620 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 【ACremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 3/19/08 STEVENSVILLE, MD 21. Signature of Funer Lice vee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 130 SPEER RD. CHESTERTOWN, MD 21620 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease, or com shock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respirator **Physician** Zdays /Medical Due to (or all a consequence of) Examiner Stress Syndrome 7+6 spirato curvitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed burial-trar Due to (or as a consequence of) physician s the burial Box 68760 Physician/Medical as IF FEMALE: for use If yes, outcome pf pregnancy
1□Live pirth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. the detached 9 Unknown 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ e e 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 XNo 1 Yes 2 No 1 ☐ Yes Division or Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1' Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? Certification: 1 Natural
2 Accident (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. To the Hospital or Attend within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 1 4 ☐ Homicide filled 29a. Certifier 🕯 🕊 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 13/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21209

ms

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

SILLART

R

7601 OSLER DRIVE m.D 32. Resistrar's Signature

10 WSON

ORIGINAL

			For State	State of Ma		partment of F Partificate of			giene Reg. No. ? A A A	10000
	100		Registrar 1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	3. Time of Death
	Physici /Medio		DEBORAH NOVICK KUS					MARCH 1		3:40 P M
	Examin	er	4a. Facility Name (If not institution, give s MONTGOMERY GENERAL				r Location of Death		4c. County of De	TGOMERY
	Funeral	1	Social Security Number 6. Sex	7. Age	(In yrs. last birthda			8. Date of Birt		rthplace (State or Foreign Country)
-	Director		377-34-6440]M 21XTF	80 Yrs.	IVIOTITIS Days	Hours Will.	09/11/1	1927 WAS	SHINGTON, DC
	land ow it		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	_ocation	-			10d. Inside City Limits
	Mary a-f sh ified a	tor	MD MONT	GOMERY		SII	LVER SPRI	NG		1XYes 2 □ No
	ith the or 283	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	•
	s 23a		14545 KELMS	SCOT DRIVE 12. Was Decedent E		Was Decedent of F	20906	ecify Yes or No		S.A.
36	be filed within 72 hours after death with the Maryland that Hygiene. cd other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	Armed Forces? 1 Yes 2 XN If Yes, Give Year or Dates:		s. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🛣 No	Specify:	Rican, etc.)	Black, Wh	
21215-0036	72 ho "natur dical E	Completed	15. Decedent's Edu (Specify only highest grade	cation e completed)	16a. Dec	edent's Usual Occup ve kind of work done DO NOT use retire	oation during most of work	king	16b. Kind of Busines	s/Industry
121	within iene. than "	dmo	Elementary/Secondary (0-12)	College (1-4or 5-	+)	ECUTIVE S			DEFENSE C	ONTRACTOR
Dd 2	be filed tal Hygid d other event, the	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nam		Maiden Surname)	TDC
Maryland	should be nd Menta marked matic ev	은	LOUIS N		401.14	Ti 1 da (Ot	A North Co. Co.		ARAH ROSENE	
Mai	12s har ris rrau	Ι.,	19a. Informant's Name/Relationship (Ty, SHERYL B. ROTHSTE)						MARYLAND	20854
re,	st 1 and 2 of Health item 27 i	Į į	20a. Method of Disposition			position (Name of rematory or other pla	ce)	Date	20c. Location - City of	
Baltimore,	ment ant: Hant: Hant: H	l y	1 ☑ Burial 2 ☐ Cremation 3 ☑ H 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	KING DAV	ID MEML G	DNS 03/13	,		CH, VIRGINIA
Ball	permit. Pages 1 and Department of Healt Important: If item 27 any injury or other t	9 9	21. Signature of Funeral Service License	Stottle.	nyer	-1091 ROCK	CVILLE PI	KE, ROCK		RYLAND 20852
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final	ications that caused ne cause on each line	the death. Do not e	nter the mode of dyl	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
b	Physician / /Medical		disease or condition resulting in death)	a. Stell	consequence of):					
	Examiner		Sequentially list conditions	PNE	umo	NIA				
4 *	ed isit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):	1				
Ć,	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):	101				
68760,	ate be nysicia he bur	dical		d						
% ×		/Med	IF FEMALE:	:3c. If yes, outcome p	of pregnancy				23d. Date of o	Ialiyanı
.O. Box	that the death certiff led by the attending detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	B⊟Ectopic pregnand □ Other (specify) _	ey .		Month	Day Year
0	requires that the een signed by th hould be detache	by Ph	Part II. Other significant conditions con	ntributing to death bu	t not resulting in the			23e. Did t		to the cause of death?
ord	w require been sig should b	ted	- HISHEIM E	2 DE	ANTO	IAL	PND_	1 🗆		Probably 4 ☐Unknown
or Vital Records,	The law ate has b page 2 sl	Completed	STAGES					24a. Was autoj perfo 1∐ Yes		
Vita	Physician; Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oti	26. Place of Dea			
0		1: To	27. Manner of Death	28a. Date of Injur	y 28b. Time	of 28c. Inju	4 ☐ Nursing H		dence 6 □Other (S) how injury occurred	pecify)
ion	Attending r death. ector: After by the fune	ation	1 ☑ Natural 5 ☐ Pending investigation	(Month, Day	Year) Injun		Yes 2□No			
Division	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of inju building, etc		street, factory, office		28f. Location (City or To	Street and Number or wn, State)	Rural Route Number,
	To the Hospital or Avivitin 24 hours after of To the Funeral Direct completely filled in by	Medical (29a. Certifier (Check only one) 1 ✓ Certifying Phy 2 ☐ Medical Exami	sician: To the best on Iner: On the basis of and manner sta	examination and/or	ath occurred at the t investigation, in my	time, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and manner , date and place, and c	as stated. lue to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	m A		29c. Licen	se number	(4	29d. Date signed (Mo	onth, Day, Year)
	6		· SATURN	(11.17)),	150	00702	-	3/11/20	JUK
_	Ψ		30. Name and address of person who co	001.	(*)	I PRINCE	PHILIP DR	, OLNEY	, MARYLAND	20832
RX	Sta Registr		31. Date filed (Month Day, Year)	32. pegistra	ar's Signature	Parts.				

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item# 2, 3 State of Maryland / Department of Health and Mental Hygiene rjw Cecil Co. 03/14/08 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Peath Am Month Year Physician Knauer 11136 Kobert March **5** 11 2008 James /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1**X** M 2□ F 65 212-40-6163 Director March 28, 1942 Maryland Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notifiled at 1XXYes 2 No Director Maryland | Laurel Anne Arundel 10f. Zip Code 10g, Citizen of What Country? 10e Street and Number 3344 Sudlersville South 20274 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1X Yes 2 No 970 If Yes, Give 1970 Year or Dates: 197 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: American Indian þ 3 Widowed 4 □ Divorced 1977 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 Elementary/Secondary (0-12) College (1-4or 5+) Law Enforcement d 2 should be filed w th and Mental Hygier 7 is marked other th Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Knauer ပ Eva Mae Bailey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Pages 1 and 2 s
Department of Health an
Important: If item 27 is,
any injury or other trau. P.O. Box 218008, Nashville, TN Terri Renee Knauer/daughter 37221 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-15-2008 North East, Maryland North East UM Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
R.T. Foard Funeral Home, P.A. 111 S. Queen St., Rising Sun, MD 21911 chand 23a Part. Enter the disease, or complicator's that can ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sh. kk, or heart failure. List only one can see in h line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Intracerebral henorrhye 2 days /Medical Due to (or as a consequence of): Examiner Stroke Ischmic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed and burial-trar Due to (or as a consequence of): physician Box 68760 Physician/Medical the as attending IF FEMALE: ase 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0. 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Infarction Myocardial 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 certificate 1 Yes 2 No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospital or Attending Injury 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Funeral Director: rtely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 24 and manner stated. the the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of 2 D0066613 March 12, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10+1VA JOSEPH JORDAN, MO, OLD, THE JOHNY HOPKIN HOLFITAL, GUO NURTH WOLFE SPEET, BAUTMORE, MARYLAND 21287 31. Date filed (Month, Day, Year) State Registrar MAR 1 4

			State of Maryland				ental Hygi	ene					
			1 - State Registrar	Cer	tificate of De			g. No. 2008	10094				
4	Physici	an	1. Decedent's Name (First, Middle, Last)				Date of Death Month	Day Year	3. Time of Death				
1	/Medic	al	MARY E. KROUSE 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Loc		MARCH	22 208 4c. County of Death	11:20 AM				
	Examin	er	10(1)		FLKTON.	calloff of Death		CECH					
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las	st birthday)	If Under 1 Year If		B. Date of Birth	9 Rinth	place (State or Foreign				
	Director		220–22–0338	Yrs.	Months Days H	Hours Min.	(Month, Day, 6/1/1920		nsylvania				
	pu »		Usual Residence of Decedent 10a, State 10b, County 10c, City,	Town or Lo	cation				10d. Inside City Limits				
	fanyla shoved at	ō	PA York Delt						1 ∐Yes 2 ⊠No				
	the N 28a-f notifi	Director	10e. Street and Number	-a	10f, Zip Code		10	g. Citizen of What Cou	intry?				
	aa or		75 Thompson Road		17314			USA					
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. \	Vas Decedent of Hispa f Yes, specify Cuban, N	anic Origin? (Spec	ify Yes or No-	14. Race - Amer Black, White					
ထ္	after or ite		1 □ Never Married 2 □ Married 1 □ Yes 2 → No			Specify:	icari, etc.)		nite				
8	nours ural'; I Exa	d b	3 X Widowed 4 ∐ Divorced Year or Dates:										
<u>7</u>	n 72 h "nat edica	Completed by	(Specify only highest grade completed)	(Give	lent's Usual Occupation kind of work done durir DO NOT use retired)		9 '	b. Kind of Business/Industry					
12	withi iene. than the M	шо	Elementary/Secondary (0-12) College (1-4or 5+)	Bookk	eeper		(Civil Serv	ice				
b	e filed al Hyg other	Be C	17. Father's Name (First, Middle, Last)		18.	. Mother's Name	(First, Middle, M	aiden Surname)					
/lar	should be filed within 72 hours after death with the Maryland and Mental Hyglene. s marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	To E	Harvey Ray Flaharty	Flaie Gertrude Bair									
Maryland 21215-0036	2 sho and I s me		19a. Informant's Name/Relationship (Type. Print)		g Address (Street and		•	City or Town, State, Z	ip Code)				
<u>ر</u> ک	iges 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hyghene. If item 27 is marked other than "natural", or items 23a or 28a-f show if item 27 is marked other than "natural", or items 25a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		Leslie King/Granddaughter		hompson Ro			17314 0c. Location - City or 1	Four State				
Baltimore,	it of H		Transunal 2 Ucremation 3 Unemoval from State		sition (Name of natory or other place)	1		•					
≣	it. Pa Intmer Intmant Injury		4 Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee		Cemetery Name and Address o	3/26/2	008	Airville,	PA				
Ba	permit. Pages 1 and 2 Department of Health a Important; If item 27 Is any Injury or other tra		2 Colland P. None College				. Inc.	600 Main	St.Delta.PA				
			Harkins Funeral Home, Inc., 600 Main St.Del 234. Part. Enter the disease, or complications that caused the decay. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Enterval Enterv										
	Physician	8 5	Immediate Cause (Final disease or condition a. BREAST	C A	JCER				Onset and Death				
	/Medical		resulting in death) a. Due to (or as a conseque	ence of):									
	Examiner	Examiner	Se mentially list conditions	contially list conditions. leading to immediate. Enter Underlying to Disease or injury litated events C. CONCESTIVE HEART FAILLIRE									
	pe tis		if any, leading to immediate cause. Enter Underlying		1 KGAO T	=00	05						
	xecuti and il-tran	хап	Cause (Disease or injury that initiated events resulting in death) Last c. CONCESTIVE HEART FAILURE Due to (or as a consequence of):										
8760,	icate be executed physician and s the burial-transit	dical E											
687	ifficate g phy as the	ledic	0.		-								
ŏ	The law requires that the death certificate has been signed by the attending progge 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal of		Ectopic pregnancy			23d. Date of deli					
Records, P.O. Box	e deat he att	sici	1 Yes 2 No 4 Pregnant at time of dea		Other (specify)			Month	Day Year				
<u>Ч</u>	res that the de signed by the a be detached f	Phy	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to										
ď,	ires the signeral be d	by	Part II. Other significant conditions continuing to death but not result	ing in the di	idenying cause given ii	iii raiti.	1 ☐ Yes		obably 4 □Unknown				
Ö	w require been sig should b	Completed					24a. Was an	24h Wara au	toney findings available				
Be	he lav has ge 2 g	Idm			· · · · · · · · · · · · · · · · · · ·		autopsy perform	prior to death?	topsy findings available ompletion of cause of				
Vita	in: Tificate or, pa		25. Was case referred to medical		26	6. Place of Death		No 1 □Yes	2 No No				
	ysicia is cer direct	o Be	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ El	R/Outpatien	Other			nce 6 □Other (Spec	cify)				
Division or	ng Ph ter th neral	n: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	2	8d. Describe hov	w injury occurred					
<u>S</u>	endir eath. or: Al	atic	2 Accident investigation			s 2 □ No							
Ë	or Att fter de Direct in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At hom building, etc. (Specify)	ne, farm, str	eet, factory, office	2	8f. Location (Str. City or Town,	eet and Number or Ru , State)	ral Route Number,				
	pital ours a eral [29a. Certifier 1⊠ Certifying Physician: To the best of my know	ledge, deatl	occurred at the time	date and place, a	nd due to the ca	use(s) and manner as	stated				
	To the Hospital or Attending Physician: The lawithin 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.										
	To the within To the complex	Me	29b. Signature and title of certifier		29c. License nu	umber	29	d. Date signed (Monti	n, Day, Year)				
			M.D.		Dool	04670		1ARCH 22	- 2008				
			30. Name and address of person who completed cause of death (Item 2		Print)				-, 2008 D 21922				
			MONIQUE PRATT- LIBUNAY		M.D. 101	6 BOW	ST. EL	KTON, M	D 21762				
	Sta Registi		31. Date filed (Month, Day, Year) MAR 2 8 2008 Registrar's Signatu	ire	47								
	5,00		WILLIA O And Contraction of the	6 1	-17								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Shawki Kaibni Shukri March 12. 2008 12:50p /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 19435 Brassie Place, Apt. 101 Montgomery Village Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months 1**X** M 2 □ F 213-80-6338 77 Oct. 12, 1930 Palestine Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location show 10b. County notified at 1 ☐ Yes 2 ☐ No Director Maryland - 28a-f Montgomery Montgomery Village 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ıral", or items 23a or Examiner must be 19435 Brassie Place, Apt. 101 20886 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2\$ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2√€No Specify Specify: White þ 3 ☐ Widowed 4 ☐ Divorced 'natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important; if Item 27 is marked other the any injury or other traumatic event, the once. 12 Chef Hospital 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Shukri F. Kaibni Nabiha M. Katwan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 20886 Azizeh Kaibni/Wife 19435 Brassie Place, Apt. 101, Montgomery Village, MO Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 14 March 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2008 Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc 500 University Blvd, W., Silver Spr Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) Urothelial Cancer vear /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed burial-trar Due to (or as a consequence of) Records, P.O. Box 68760, attending physician Physician/Medical the nse 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 DEctopic pregnancy Month Vear Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown cate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform 1 Yes 2 No Division or Vital 25. Was case referred to medical examiner? Be (26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2□ No 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Certification: To this funeral 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Injury (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No М Hospital or Attendi
 24 hours after death.
 Funeral Director: A etely filled in by the ft death. 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide ۲ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

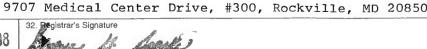
To the within To the

the

State Registrar

31. Date filed (Month, Day, Year) MAR 1 4 2008

Paul Thambi, MD



were

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

DO061083

29d. Date signed (Month, Day, Year)

MAR 13, 2008

		Please Type or Pr				-	_	e.	
		1 - State of N Registrar	laryland /	Department of Certificate of		•	giene Reg. No. 20	08 10096	
Physicia /Medic		lames Arrour Krevendini							
Examin Funeral Director	er	5. Social Security Number 6. Sex 1 ☑ M 2 ☐ F 6	(V	STER C		8. Date of Bir (Month, Da July	ay, Year)		
aryland show dat	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location						10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
ith the Ma or 28a-f	Director	MD Garrett 10e. Street and Number	Oakla	10f. Zip Code			10g. Citizen of Wh	/hat Country?	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral I	1833 Broadford Rd. 11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced 1 □ Yes 2 □ If Yes, Give Year or Dates	s? ≹No	21550 13. Was Decedent of If Yes, specify Cu 1 □ Yes 2 ☑ No	Hispanic Origin? (Speuban, Mexican, Puerto	ecify Yes or No Rican, etc.)	Black,	American Indian, White, etc. White	
ithin 72 hour nen "natural" e Medical Ex	Completed b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-40	16	ia. Decedent's Usual Occ (Give kind of work don life. DO NOT use retii Go1f	upation e during most of worki red)	ng	16b. Kind of Busin		
uld be filed w fental Hygie rked other ti tic event, th	To Be Col	17. Father's Name (First, Middle, Last) 18. N				Mother's Name (First, Middle, Malden Surname) Virginia Tricket			
and 2 shou lealth and M m 27 is ma her trauma		19a. Informant's Name/Relationship (Type. Print) Julie Kreyenbuhl		9b. Mailing Address (Stree 2449 Warm S of Disposition (Name of	prings Way			21113	
nit. Pages 1 artment of F ortant: If ite injury or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	e Garre	ett Co. Mem.	Gardens 3/11	/08	Oakland Burdock	, MD	
permi Depa Impo any ir		I Garya A. Burgo	ck	21 N. 2r	nd St. Oak	land,	MD 21550	r n	
Physician and physician and physician and physician and street physician and street physician and street physician and physician	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	as a consequence	lure oon: An Atteno		r respiratory a	irest,	Approximate Interval Between Onset and Death	
ath certif	Physician/Medical		2 ☐ Fetal dea at time of death			23d. Date Mont	•		
uires that the de signed by the	þ	Part II. Other significant conditions contributing to death	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					ute to the cause of death?	
The ate h	Completed					24a. Was auto perf 1∐ Yes	opsy pri ormed? de	ere autopsy findings available or to completion of cause of ath? □ Yes 2 □ No	
To the Hospital or Attending Physician: The within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pag	tion: To Be	25. Was case referred to medical examiner? 127 Yes 2 No Hospital: 129 Npps 27. Manner of Death 28a. Date of Ir (Month, Ir 2) Accident investigation		o. Time of 28c. In Injury		me 5□Res	one) idence 6 □Other how injury occurred		
tal or Atter s after dea al Director ed in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 28e. Place of	njury - At home, etc. (Specify)	farm, street, factory, offic	ce	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
he Hospii n 24 hour he Funer pletely fill	Medical (29a. Certifier (Check only one) Certifying Physician: To the be 2 Medical Examiner: On the basis and manner	of examination	dge, death occurred at the and/or investigation, in m	e time, date and place, ly opinion, death occur	and due to the	e cause(s) and man e, date and place, ar	ner as stated. nd due to the cause(s)	
To t Withi To t	Σ	29b. Signature and title of certifier Jery Fry M			2741 5	29d. Date signed (Month, Day, Year) MARLL 8, 2008 Lical Center			
	1	30. Name and address of person who completed cause of Henry FRANCS. MD	f death (Item 23a Bh hìn	a) (Type, Print)	inter Med	1:01	(enter		
Sta Registr			strar's Signature	e South			-,-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene -Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Arthur D. Kemp 11:50a. M March 2008 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Carroll 1717 Fairmount Road Hampstead If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Days 86 6/21/1921 215-14-2489 MD. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 TYes 2 XNo Hampstead MD Carroll 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21074 USA 1717 Fairmount Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify white 3 □Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Huckster Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Howard T. Kemp Sara A. (Houck) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7407 Grave Run Rd., Glen Rock, Pa. 17327 Carl E. Kemp, son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ★Burial 2 □Cremation 3 □Removal from State 4 □Donation 5 □Other (Specify) Hampstead, Md. Hampstead Cemetery 3/18/2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eline Funeral Home 934 South Main St., Hampstead, Md. 21074

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

burial-tran asn for detached

page 2 s 124 hours after death.

In Funeral Director: A sletely filled in by the files.

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Hospital or Attending within 2 10

30. Name and address of per

ETER 31. Date filed (Month, Day, Year)

23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	one cause on each line.	mode of dying, such as cardi	ac or respiratory arrest,	Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Veyfu'a by Due to (or as a consequence of):	Sarleyo	ardia	suddey
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): C. Due to (or as a consequence of): d.	c avoly	voici la	dies 20 you.
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		oic pregnancy er (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions of	contributing to death but not resulting in the underly	ing cause given in Part I.		24b. Were autopsy findings available prior to completion of cause of death?
25. Was case referred to medical		26 Place of D	eath Check onl one	V
eyaminer?	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐		Home 5 Residence	6 □Other (Specify)
27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M	28c. Injury at Work?	28d. Describe how in	jury occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home, farm, street, fa building, etc. (Specify)	actory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
29a. Certifier 1 Certifying Phy (Check only one)	visician: To the best of my knowledge, death occupiner: On the basis of examination and/or investig and manner stated.	urred at the time, date and pla ation, in my opinion, death oc	ce, and due to the cause courred at the time, date	(s) and manner as stated. and place, and due to the cause(s)
29b. Signature and title of pertifier	7.>	29c. License number		Date signed (Month, Day, Year)
11/1/10/	111	11/21/200	2	7/11/100

State Registrar

who completed cause of death (Item 23a) (Type, Print)

10098

		•	- State Registrar 3/18/08 AACO Health Dept. CMH	Cei	rtificate of E	Death		Reg.	No.				
ľ	Dhyniai		1. Decedent's Name (First, Middle, Last)				2. Date of	of Death	Day,,	2008	3. Time of Death		
	Physicia /Medic Examin	al	Robert Thomas Kelsey 4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Cente	170	4b. City, Town, or	Location of Death			4c. County	of Death	09:20AM		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last to 148–40–9095 9075 145 M 2 F 59		thday) If Under 1 Year If Under 24 Hrs. 8. Date of B				948	ace (State or Foreign			
	Director		Usual Residence of Decedent					7 07			d. Inside City Limits		
	e Marylan a-f show ified at	ctor	10a. State 10b. County 10c. City, To MD Anne Arundel Se		1 □Yes 2X No								
	vith the	Funeral Director	10e. Street and Number		10f. Zip Code	1//		10g. Citizen of What Country? USA					
	leath v	eral	1427 Evergreen Rd. 11. Marital Status 12. Was Decedent Ever in U.S.	13.	Was Decedent of Hi If Yes, specify Cuba	144 spanic Origin? (Spe	ecify Yes	or No-	14. Rad	ce - America			
3-002p	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygjene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced Armed Forces? ★□ Yes 2 □ No 1968 − If Yes, Give Year or Dates: 1988		if Yes, specify Cuba 1 ☐ Yes 2 No	n, mexican, Puerto Specify:	Hican, et)	Specia	ck, White, e fy: W h	nite		
٠ -	"natur	Completed	15. Decedent's Education (Specify only highest grade completed)	ing	16b. Kind of Business/Industry								
7	l withir jene. r than the Me	ошо	Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done of DO NOT use retired				US	US Army			
ana	be filectal Hyg	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name Wilma	e (First, M	iddle, Mai	den Surna	n Surname)			
<u> </u>	2 should be filed w and Mental Hygie is marked other ti raumatic event, th	은	Raymond Kelsey 19a. Informant's Name/Relationship (Type. Print) 1	 9b. Maili	ng Address (Street a		al Route I	lumber, C	ity or Town	, State, Zip			
<u>8</u>	1 and 2 s Health ar tem 27 is		BK Kelsey Wife	1427	Evergree	n Rd. Sev	vern,	MD :	21114		¥		
ore,	ges 1 at of He If Item or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	of Dispo tery, cre	osition (Name of matory or other plac	e) ¦	Date			- City or To	*		
Dallillor	permit. Pages 1 Department of H Important: If Ite any injury or ot		4 □ Donation 5 □ Other (Specify) Metr 21. Signature of Funeral Service Digensee		ematory 2. Name and Addres	3/14,				ore, N Home			
מ	permir Depar Impor any ir once.		13. J. G	1	2 Ridgely	Ave. A	napo	lis,	MD 2		1		
			23a. Part1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line.			g, such as cardiac	or respira	tory arrest	1		Approximate Interval Between Onset and Death		
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death) ANDXIC ENCE		ALOPATHY								
	Examiner		CARDIO-RESF	IRF	ATORY AR	REST							
	ted sait	Examiner	if any, leading to immediate cause. Enter Underlying Cause, Disease or injury VENTRICULAR ARRHYTHMIA										
o î	ortificate be executed ing physician and as the burial-transit	Exar	resulting in death) Last Due to (or as a consequence	ce of):									
68/60 ,	ate be	Medical	MYOCARDIAL MYOCARDIAL	TIME	HKC LION								
C. Box 6	death ce e aftendi d for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 9 □ Unknown				23d. Date of delivery Month Day Year						
λ, J	The law requires that the tte has been signed by the bage 2 should be detache	þ	Part II. Other significant conditions contributing to death but not resultin CORONARY ARTERY DISEASE	j in the ι	underlying cause giv	en in Part I.	23e		cco use coi 2 ☐ No		ne cause of death?		
VItal Record	aw requisite peer stands	Completed	PERPHERIAL VASCULAR DISEASE				24a	. Was an autopsy	24b	. Were auto	psy findings available inpletion of cause of		
Ĭ		Com						performe Yes 2	No No	doath?	2 No		
	slcian certifii irector	Be	25. Was case referred to medical examiner? 1 □ Yes 2 No Hospital: 1 Inpatient 2 □ ER/	Outnatie	ent 3 DOA Oth	26. Place of Dea er: 4 ☐ Nursing H			се 6 По	ther (Snecif			
on or	Attending Physician: or death. ector: After this certifica by the funeral director, p.	tion: To		b. Time Injury	of 28c. Injur				injury occu		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
DIVISION	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	2 Accident 3 Suicide 4 Homicide Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or City or Town, State)							nber or Rura	l Route Number,		
	e Hospita 24 hours e Funera etely fille	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowle defical Examiner: On the basis of examination and manner stated.	dge, dea	ath occurred at the ti investigation, in my	me, date and place opinion, death occu	, and due rred at the	to the cau time, dat	ise(s) and i e and place	manner as s e, and due to	tated. o the cause(s)		
	To the within To the comple	Me	29b. Signature and title of certifier	W						ned (Month,			
			1 ICTION O	244		826			5-1	0-8	2 8		
	10+1CH	-	30. Name and address of person who completed cause of death (Item 23 RICHARD L. LINTHICUM, M. D.		o, Print) Ø1 OSLER	DRIVE	TOW	SON,	MARY	LAND	21204		
	Sta	ate	31. Date filed (Month, Day, Year) 32. Pegistrar's Signature)	1.0.								

Certificate of Death

in 24 house, the Funeral Direct Medical completely

State Registrar

LVANA GOLO, MI) 31. Date filed (Month, Day, Year)

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

29b. Signature and title of certifier

determined

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

STREET BALTIMORE, MD 21201

10057450

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

2008

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

GREENE

MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOUTH

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2008 Month **Physician** 7 Charles P. Kirby Jr 6:15 A M March /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 1444 Wisp Court Hanover Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Oct 10 19 9. Birthplace (State or Foreign Country)
D • C • 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days 65 Yrs 1942 219-40-2857 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at Maryland Anne Arundel Hanover 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1444 Wisp Court 21076 USA Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Tes 2 M If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: Black 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Anne Arundel Co. Elementary/Secondary (0-12) College (1-4or 5+) 12th 0 Chief Custodian Board of Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Kirby Helen Spencer ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annie L. Kirby(Wife) 1444 Wisp Court Hanover, Md. 21076 20a. Method of Disposition 20b. Phase of Disposition (Name of certifier), crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State Memorial Park 3-13-08 Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Mame Revenue of Arcin Cons Mortuary, P.A. Jarry S 821 West St. Annapolis, Md. 21401 MO0483 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to firm orbital cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Tue to for as a consequence of: Examine attending physician and for use as the burlal-tran Due to (or as a consequence of): P.O. Box 68760 requires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ò 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ■ Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? Certification: Hospital or Attending 1 Natural 5 Pending Injury thin 24 hours after deaun.

o the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Yertifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific D0058779 MD 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL Dr. GlenBurne and 305 egistrar's Signature 31. Date filed (Month, Day, Year) State MAR 1 1 2008 Registrar

_	For
1.	State
	Registrar

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar			Cer	tificate	e of l	Death			Reg. N	lo.		
Decedent's Name (First, Middle, Last) 2. Date of Death									3. Time of Death						
Physician Elizabeth Smith Kilmon											March	^{Day} 2008		07:11 AM	
	/Medic Examir		4a. Facility Name (If not institution, give				4b. City, Town, or Location of Death					4c. County of Death			
	LAGIIII	GI	100		Conto	_	Salis					ΓΑ7 i	icomico		
	Funeral		Peninsula Regional 5. Social Security Number 6. Se		e (In yrs. las		If Under		y If Under	24 Hrs.	8. Date of B	irth	9. Bir	thplace (State or Foreign	
	Funeral Director			TH ONE	93	Yrs.	Months	Days	Hours	Min.	03/12/	7912		yland	
			Usual Residence of Decedent								100//		Mai	yzana	
	land		10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits	
	Mary	ō	Maryland Wicomico	,	Salis	sbury								1 AYes 2 □ No	
	288 288	Directo	10e. Street and Number				10f. Zip	Code				10a. C	10g. Citizen of What Country?		
	with			w Manox D	170		2180					USA	-		
	s 23	Funeral	1015 East Schumake	12. Was Decedent		12.1			ionania Osi	ain? (Ca	noite Van ar h	L	14. Race - Ame	nican Indian	
	er de	'n	11. Marital Status	Armed Forces?		13. 1	Yes, spec	fy Cuba	in, Mexicar	n, Puerto	ecify Yes or N Rican, etc.)	10-	Black, Whit		
36	s aft	Ϋ́	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 N If Yes, Give Year or Dates:	NO	1	☐ Yes 2	2 ⊠ No	Specify:				Specify: White		
Ş	72 hours after death with the Maryland natural', or items 23a or 28a-f show dissa Exercifred at	b	15. Decedent's Ed			16a. Deced	lant's Heur	1 Occup	ation			16h	Kind of Business		
21215-0036	C "_ N	Completed by	(Specify only highest grad			(Give	kind of wor	k done d	durina mos	t of worki	ing	100.	TRAINE OF DESITIONS	madatty	
12	with Bne. thar	Ę	Elementary/Secondary (0-12)	College (1-4or 5		Homema			,			Don	nestic		
22	filed Hygi thar		17. Father's Name (First, Middle, Last)			HOME	ZICL		18. Mothe	er's Name	(First, Middl	1		· - · · · · · · · · · · · · · · · · · ·	
an	o d as D	Be	Julius A. Smith								errill		,		
$\tilde{\Xi}$	shoute nd Me n mark nmark	ဥ	19a. Informant's Name/Relationship (7	uno Printi		10b Mailie	a Addross					bor City	or Town, State,	Zio Codo l	
Maryland	~ @ @ =				1. 1		-								
	s 1 and 2 f Health itsm 27 i		Sandra Kilmon Phil 20a. Method of Disposition	lips/daug		Ce of Dispo			ıı CL.		ate		cyland 2 Location - City or		
altimore,	Pages nent of h		1 XBurial 2 Cremation 3	Removal from State	сел	netery, cren	natory or of	ther place		_					
ᆵ	Pag men tant: jury		* 4 ☐ Donation 5 ☐ Other (Specify		rai	rview	Lawn	Cell	ieret?	(3/	/13/08	Ona	ancock, V	irginia	
ā	permit. Pages Department of 8 Important: If itu any injury or o'		21. Signature of Funeral Service Licen	:00	0		. Name and				ome P.A				
<u>m</u>	205 20		1 John 1 ha	my (+St		5	01.5	ow E	ill i	2d. 3	Salisbu	ry,	Maryland	21804	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused	the death.	Do not ente	er the mode	e of dyin	g, such as	cardiac o	or respiratory	arrest,	-	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	Sepas										Onset and Death	
Н	/Medical		resulting in death)	a. Due to (or as	a conseque	nce of):									
	Examiner			. Cloth	Ju. in	~ 1	iffer	10	Coli	tis					
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	nce of):	J								
	uted d ansit	Ë	Cause (Disease or injury that initiated events												
	exector and all-tra	Examiner	resulting in death) Last	Due to (or as	a conseque	nce of):									
92	sicia buri	al		d											
68760,	certificate be executed ding physician and se as the burial-transit	ledical		u											
×	certi	/W	IF FEMALE:	23c. If yes, outcome	of pregnanc	y							23d. Date of de	iverv	
Bo	atter for u	ciar	23b. Was decedent pregnant in the past 12 months?	1⊡Live birth 4⊡Pregnant at			Ectopic pre						Month	Day Year	
P.O.	The law requires that the death on the has been signed by the attenbage 2 should be detached for u	Physiciar	1 □ Yes 2 □ No 9 □ Unknown	9□Unknown			(
	that ed by deta		Part II. Other significant conditions co	ntributing to death b	ut not resulti	ing in the ur	derlying ca	ause give	en in Part I		23e. Did	tobacco	use contribute to	the cause of death?	
of Vital Records,	sign d be	d by									1	Yes 2	2 □ No 3 □ Pr	obably Wonknown	
Ö	w require been sig should t	Completed									24- 146		0.45 19/2 20 20	to a diament and a land	
Sec.	e law has le 2 s	du										s an opsy formed2	prior to death?	topsy findings available completion of cause of	
=		Ö									1 ☐ Yes	2 2 N		2 🗆 No	
/its	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?					0.1		of Death	(Check only	one)			
Ž	d is	ဥ	TE TOS VE NO	Hospital: Inpatie		R/Outpatien			4 🗆 NU				6 ☐Other (Spe	cify)	
_	Jing P. After I	on:	27. Manner of Death 1 ■ Natural 5 ■ Pending	28a. Date of Injui (Month, Day	ry y Year) 2	8b. Time of Injury		Bc. Injun Work			28d. Describe	how inj	ury occurred		
Sio	Attanding ir death. ector: After by the fune	atl	2 ☐ Accident investigation				М	1 🗆 '	Yes 2 🗆	No					
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju- building, etc		e, farm, stre	et, factory,	, office			28f. Location City or To			ural Route Number,	
Ω	ital c	Se													
	To tha Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier Certifying Phy (Check only 2 Medical Exam	iner: On the basis of	f examination	edge, death n and/or inv	occurred a restigation.	at the tim	ne, date an pinion, dea	d place, a	and due to the	e cause(, date ar	s) and manner as nd place, and due	s stated. e to the cause(s)	
	To tha Pwithin 24 To the F	led	one)	and manner sta	ated.										
	To To Con	Σ	29b. Signature and title of certifier	Q			290.		3199	}		∠9d. D	ate signed (Mont	n, Day, rear)	
	Lh		7/				1-	0	211	b		0.	2 14 20	~ 8	
1			30. Name and address of person who o		eath (Item 2	3a) (Type,		1		_	20		,		
			YOGESH VOHR		EAST	PERN	SHOR	E 1	L, .	SAU.	SBURY	MI	21864		
	Sta		31. Date filed (Month, Day, Year)	32. Fregistra	ar's Signatur	2	back.	8					•		
	Registr	ar	1 1 5	The state of	income agen	A Paris	Median Ca	1.7							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** NANCY CATHERINE LUCAS 5 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner eha ova If Under 1 Year Birthplace (State or Foreign Country) Age (In yrs. last birthday) If Under 24 Hrs. Hours Min. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 ☐ M 2 🗶 F Director 215-44-6725 9/3/1946 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director MD HARFORD BEL AIR 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 21014 USA 700 HERITAGE LN. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black. White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: ģ 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) STATE OF MARYLAND ADMINISTRATOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FRANCES BIDDLE CALVIN LUCAS ပ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 ANTHONY RD. CHESTERTWON, CALVIN LUCAS/FATHER MD 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) CHURCH HILL CEMETERY 3/19/08 CHURCH HILL, MD 21. Signature of Funeral Service License FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME Juk 130 SPEER RD. CHESTERTOWN, MD 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical r as a conse plence of) **Examiner** 20 U Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed and burial-trai Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use ontribute to the cause of death? þ 2 No 1 TYes 3 Probably 4 Unknown Completed page 2 should .24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No aw 24a. Was an certificate has autopsy performe es 2 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? Be (director, 26. Plage of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Tes Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA this 27. Manyler of Death funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation Injury 1 🗌 Yes 2 □ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

Records, 24 hours after death Puneral Director: Hospital the ု့

Baltimore, Maryland 21215-0036

10 State

Registrar

31. Date filed (Month, Day, MAR 19 2008

ss of person who completed cause of

29b. Signature and the of certifier

29a. Certifier

30. Name

Medical

(Item 23a) (Type, Print)

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Division or Vital Records, P.O. Box 68760. or Attending Physician: within 24 hours after death To the Funeral Director:

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who campleted cause of death (Item 23a) (Type, Print) NO 21620 MATTHEW I. KING m.c State Registrar

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

6 Could not be determined

3 Suicide

4 Homicide

DHMH 17 Rev 1/2001

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2008 Sallie Billie Letio /Medical or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Taryland 5. Social Seconty Number If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🖫 F 79 247-64-4343 August15,1928SouthCarolina Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show 23a or 28a-f shoust be notified at Y∏Yes 2 No Maryland Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21206 1100 Pennsylvania Avenue U.S.A. Funera 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married or 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify:Black þ 3 ₩ Widowed 4 Divorced 'natural", Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 721 (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Private Duty Sitter Health Care 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland Be Pages 1 and 2 should be Elo Billie Lela Caldwell မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O.Box8472, Jacksonville, Florida 32239 <u>Melody Jones</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 □ Qurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 3-22-08 Brown Cemetery Pinewood, SouthCar. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. mechael marghely 6009Harford Road, Baltimore, Maryland21214 23a. Part1. Enter the disease, or combifications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Intaration ocardia /Medical s a consequence of Examiner Sequentially list conditions Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed burial-trar and Due to (or as a consequence of): physician s the burial Box 68760 Physician/Medical as IF FEMALE use 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ò Month Dav Year 4□Pregnant at time of death 5 Other (specify) signed by the a Id be detached fo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably cate has been sig , page 2 should b Diabit 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? res 2 No certificate 1 Yes director, 25. Was case referred to medical 26 Place of Death (Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2DER/Outpatient 3 □ DOA 1 Yes 2 No 1 Inpatient P this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation Hospital or Attending 1 Natural Injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated. Medical 29a, Certifier (Check only one)

P.O. Records, Vital Division or

State

31. Date filed (Month, Day, Year) MAR 2 8 Registrar

30 Name and

29b. Signature and tit

Anje Kim

address of perso



who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

08-02247	
Sharon A	nn Little

haron Ann Little		St 1- For State Registrar	ate of Maryla		artment of rtificate of		Menta	l Hygiene	Reg. N	do 21	ne	s loin
Physicia Medical Examir	n/	1. Decedent's Name (First, Midd Sharon Ar	n Little			_		2. Date o Month March	f Death	v Year	3.	Time of Death 1058 hrs
		4a. Facility Name (if not institution 26 N. Main Street	-			b. City, Town, or L Union Bridge	9			4c. County of Death Carroll		
Funeral Director		5. Social Security Number 214–90–0748	6. Sex	7. Age (In yrs. 44	last birthday) Yrs	If Under 1 Year Months Days	If Under 2 Hours	Adin		1963	9. Birthp Foreign <u>I</u> Count	lace (State or Maryland ry)
daryland 28a-f show any		Usual Residence of Decedent 10a. State 10b. County Maryland Cai	rroll	10c. City	, Town or Locati		on Bri	dge				Od. Inside City Limits Yes 2 No
tor 28a-fs	읤	10e. Street and Number 26 N. Main Stre	eet		-	10f. Zip Code	217	 791	10g. (Citizen of Wha	t Country USA	R
s afte	by Fune	11. Marital Status 1 Never Married 2 MM 3 Widowed 4 Div 15. Decedent's Education (Spe	Armed F 1 Yes /orced If Yes, Give Yes or Dates:	2 No	If Y	S Decedent of Hispes, specify Cuban, Yes 2 No t's Usual Occupati	Mexican, Possible Specify:	uerto Rican, et	G.)	White,	_{etc.} hite	
5-0036 ted within 72 hour Hygiene. other than "natt	Completed	Elementary/Secondary (0-12)		1-4 or 5+)	during m	ost of working life. Tomemaker					Hom	_
Ore, MD 21215-0036 yes I and 2 should be filed within 7 of Health and Menial Hygiene. If Item 27 is marked other than ther traumatic event, the Medica	8	17. Father's Name (First, Middle James Edwa)	rd Green				En	Name (First, Minily Sm.	ith	ŕ		
	_	19a. Informant's Name/Relations Douglas E. Litt 20a. Method of Disposition			26 N.	Address (Street Main St	, Box	261, Ui	nion	Bridge	, MD	21791
Pag Pag ment fant:		1 Burial 2 Cremation 4 Donation 5 Other S M Signature of Funeral Service	pecify:	om State	crematory or oth	er place) Bible Ce	em. 3	3/27/200	08	Westmi	nste	r, MD
Balt Depart Import		23a Part I. Enter the disease, or	complications that of	aused the death		willis and mode of dying,						HOME 57 Approximate Interval
/Medical xaminer	+	failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	a. Seizuro	e disorde								Between Onset and Death
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		consequence of	of):							
e executed be executed cian and rrial - transit	al Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence o	of):							
Sox 68760 leath certificate be attending physifor use as the bu		IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day 1 Yes 2 No 9 ✓ Unknown 4 Pregnant at time of death 5 Other (Specify)								y Year		
ires that the c	≦	Part II. Other significant condit	tions contributing to	o death but not r	resulting in the u	nderlying cause gi	ven in Part I	1. 23e. 1		cco use contrib		e cause of death?
of Vital Records, P.O. ag Physician: The law requires that the this certificate has been signed by increal director, page 2 should be detected.	Completed							- [_	Was an autopsy performed Yes 2	d? pri		osy findings available npletion of cause of 2 No
ital Rec	8	25. Was case referred to medica examiner?	Hospital:	Inpatient 2	ER/Qutpatient		Othor:	neck only one) lursing Home	E □ Boo	sidence 6	Othory	2000
ion of Virtending Physicath. or: After this the funeral dis	ation: To	1 ✓ Yes 2 No 27. Manner of Death 1 ✓ Natural 5 Penc 2 Accident Inves	28a. Date (Month		28b. Time of I	njury 28c. Injury	at Work?	28d. Des		injury occurred		Defic
Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director: /	Certification:	3 Suicide 6 Coul	stigation 28e. Place 28e. Place (Specify)	e of Injury - At h	ome, farm, stree	t, factory, office bu	ilding, etc.		ition (Stree own, State		or Rura	Route Number, City
To the Hospital within 24 hours a To the Funeral I completely filled	edical	one) 2 Medical Exa	hysician: To the bes miner:On the basis and manner s	of examination a								
NST	Σ	29b. Signature and title of certific	The You	ll		29c. License				id. Date signed Narch 22, 2	•	ı, Day, Year)
		30. Name and address of person Margarita Korell MD.	Assistant Med	dical Examir	ner 111 P	enn Street, Ba	Itimore, N	MD 21201				
Sta Registr	122	31. Date filed (Month, Day, Year) MAR 2 4		gistrar's Signati	ure K Los	the same						
DHMH 17 Rev 1/200	01				ORIGINA	_						OCME

that the death certificate be executed attending physician and for use as the burial-trar P.O. Box 68760 Division or Vital Records,

the Hospital or Attending Physician: 'hin 24 hours after death.
the Funeral Director: After this certifica mpletely filled in by the funeral director, p To the .
within 24 hour.
To the Funeral D'

Funeral

Director

show

"natural", or Items 23a or 28a-f shovidical Examiner must be notified at

the Medical

hours after

72

filed within 7 I Hygiene.

permit. Pages 1 and 2 should be filed w. Department of Health and Mental Hygien. Important: If Item 27 is marked other tha any Injury or other traumatic exercises.

Physician

/Medical

Examiner

Maryland 21215-0036

Baltimore,

Cel

- 1	5
- 1	드
	-
	.2
	2
	2
	о.
	>
- 1	=
- 1	9
Ī	to to
	õ
	ᇀ
	0
	C
	Φ
	Ď
	.0
	\vdash
	Ë
	0
	at
- 1	Ü
	至
- 1	4~

2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 **ZCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Location of the death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Location of the death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 03/12/2008

D0065733

smeet

SWL 3B ELKTON, 17D 21921

State Registrar

31. Date filed (Month, Day, Year) 2008 MAR 1 4

NARAYANA

P.V. Nanger

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAO



1553 hrs

Approximate Interval Between Onset and

Death

29d. Date signed (Month, Day, Year)

March 23, 2008

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Division of Vital Records, P.O. Box 68760,

l Examiner	cause. Enter Underlying Cause (Disease or injury that initiated C	e to (or as a consequence of):				
dical	X UNPENDED	AMENDED 23a,27,28a-f g878 per ME 4/2/08 amh				
nysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnance 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	су	23d. Date of delive Month	ry Day	Year
ompleted by P	Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.		24b. Were a prior to death?	obably 4 autopsy fir completi	
اد	25. Was case referred to medical	26.Place of Death (Check on	ly one)			
0	examiner? 1 ✓ Yes 2 No	pital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing	Home 5 Re	esidence 6 🗸 Othe	er: Scene	
rtilication:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 X Could not be determined	Found 3/22/08 Found 3:35pm 1 Yes 2 X No U 28e. Place of Injury - At home, farm, street, factory, office building, etc.	or Town, State	eet and Number or Re) 3605 4th S	ural Roul	e Number, City
aulcai ce	one) 2 Medical Examiner:	To the best of my knowledge, death occurred at the time, date and place, and dun the basis of examination and/or investigation, in my opinion, death occurred at the manner stated.		s) and manner as sta		(s)

State Registrar

OCME

29b. Signature and title of certifie

Mary G. Mpple MD.

31. Date filed (Month, Day, Year)

ess of person who completed cause of death (Item 23a)

Deputy Chief Medical Examiner

32. Figistrar's Signature

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

Registrar
DHMH 17 Rev 1/2001

State

ORIGINAL

umberland

Haryland 21502

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Laman

2008

1. Date filed (Month, Day, Year)

MAR 2 8

904

Seton Wrive

32. Registrar's Signature

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed attending physician for use as the buria page 2 s certificate Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** William McDonald 2008 MARCH 23 11:57 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CUMBERLAND r 1 Year | If Under 24 Hrs. ALLEGANY MEMORIAL HOSPITAL If Under 1 Year 8. Date of Birth (Month, Day, Year) Aug 14, 1932 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 □ F MD 217-30-1452 Director 75 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County MD Allegany Cumberland 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 31 Arch Street 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: Korea Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 □ Yes 2 □ 📉 Specify: Specify: þ 3 ☐Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) custodian Allegany Bd. of Ed. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George E. McDonald Sadie M. Knepp McDonald 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary McDonald wife 31 Arch Street MD 21502 Cumberland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Deurial 2 □ Cremation 3 □ Removal from State Pleasant Grove Cemetery 3/26/2008 MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fu eral Service Licensee 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a, Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immer e Cause (Final disea e or condition resulting in death) VENTRICULAR TACHYCARDIA MINUTES Due to (or as a consequence of): ISCHEMIC CARDIOMYOPATHY UNKNOWN Se pontially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐Yes 2☐No 24a. Was an autopsy 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 🔲 Yes 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 008 D0065702 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ATYER 900 SETON DRIVE, CUMBERLAND, MD 21502 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar DHMH 17 Rev 1/2001

DIC

MAR 2 8

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date Month 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Louise A. McCutcheon 12 08 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Prince George's Renaissance Cardens at Riderwood Village Silver Spring If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7 Pt. 12, 1912 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Pennsylvania 1 □ M 2 🔽 F 96 177-03-3501 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene, 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 🔽 No Silver Spring Maryland Montgomery Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20904 3118 Gracefield Road,#315 United States Completed by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 🏖 No Specify: Baltimore, Maryland 21215-0036 3 Widowed 4 □ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) Homemaker own home permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other than yn jury or other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Belle Hartzell Robert W. Allison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Robert Bruce McCutcheon -son 3321 Blackberry Lane Davidsonville, Maryland 21035 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 3/13/2008 | Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Bonald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (r 's a consequence f): /Medical **Examiner** lung cance Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as consequence of) Examiner The law requires that the death certificate be executed the burial-tran and Due to (or as a consequence of) physician Division or Vital Records, P.O. Box 68760 Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year Day in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ should be 1, ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ostcoporosis has autopsy page performed' 2 No certificate or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner' Hospital: Other: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After Injury Natural 5 Pending M 1 ☐ Yes 2 ☐ No To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: All completely filled in by the fu investigation 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year)

MAR 1 4 DHMH 17 Rev 1/2001

Rachelle

3110

32. Resistrar's Signature

Gracefield Rd Silver Spring

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Alexian

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day OUIDA V. MAEDEL Physician March 8, 2008 8:30 A.M. /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Kensington Nursing, LLC Kensington Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday 5. Social Security Number 6. Sex 1 □ M 2 🕅 F 83 March 9, 1924 Tennessee 217-12-7185 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 XYes 2 No Washington D.C. N/A Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20017 United States 1320 Irving Street, NE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, 11 Marital Status Black, White, etc.
Black
Specify: 1 Never Married 2 Married 1 □ Yes 2 No Specify þ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Education Administration Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maud Ethel Cameron Hubert Moman ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) William A. Maedel, Jr./Son 1700 Allison Street, NE, Washington, D.C. 20017 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Dispesition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Chesapeake Crematory March 13,2008 ake Crematory March 13,2008 Beltsville, Maryland 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Service Licens 7400 Georgia Ave., NW, Washington, D.C. 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Hypertension Due to (or as a consequence of): Diabetes Mellitus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23h Was decedent pregnant Be Completed by Certification: To

The law requires that the death certificate be executed and burial-tra Division or Vital Records, P.O. Box 68760, aftending physician the as nse for sate has been signed page 2 should be det Physician: this After

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any linjury or other traumatic event, the Medical Examiner must be notified at once.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

Hospital or Attending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

in the past 12 months? 1 □ Yes 2¶ No 9 □ Unknown	1⊔Live birth 2 ⊔ Feta 4 □ Pregnant at time of d 9 □ Unknown				Month Day Year
Part II. Other significant conditions	contributing to death but not res	ulting in the underlying	cause given in Part I.	23e. Did tobacco us	se contribute to the cause of death?
Alzheimers Dise	ease			1 ☐ Yes 2 [□ No 3 □ Probably 4X □ Unknown
				24a. Was an autopsy performed? 1 Yes 2 XNo	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical examiner? 1 ☐ Yes 2 [X]No	Hospital: 1 Inpatient 2	ER/Outpatient 3 □ D	Othor:	ath <i>Check onl one</i> Home 5 ☐ Residence 6	6 □Other (Specify)
27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	y occurred
3 Suicide 6 Could not 4 Homicide determined		ome, farm, street, facto	ry, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,)
	Physician: To the best of my kno aminer: On the basis of examina and manner stated.				

29c. License number

D0064624

29d. Date signed (Month, Day, Year)

March 12,2008

10

Sandeen Sharma, Md 3000 McComas Avenue, Kensington Maryland 20895-2316

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical

29b. Signature and title of certifier

08-02101 Thian Mung

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day March 15, 2008 1333 hrs Thian Mung Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Frederick Frederick Frederick Memorial Hospital If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Months Days Hours Director 586-45-8543 05/07/1967 1X M 2 40 Burma Yrs Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 X Yes 2 No Maryland Frederick Frederick notified at once. Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5746 Butterfly Lane hours after death with the 21703 Burma Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married 2 X No Ves 1 Yes 2 X No specify: Widowed Divorced Yes. Give Year Specify: Asian Pages 1 and 2 should be filled within 72 hours after truent of Health and Mental Hygiens.
 Pis marked other than "natural", "or other fraumatic event, the Medical Examiner. ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 Transportation Truck Driver 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Son Za Hau Cing Kho Man 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5746 Butterfly Ln. Frederick. Friend Khai Pau MD20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition March 22. crematory or other place) Restnaven 1 X Burial 2 Cremation 3 Removal from State 2008 Frederick, Maryland Memorial Gardens 4 Donation 5 Other Specify Restnaven Funeral Services, Skkot Cody P.A 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 21. Signature of Funeral Service Licensee Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. /Medical Death Immediate Cause (Fine disease a Cardiac Arrhythmia due to Mycardial Fibrosis Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to for as a consequence of: if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical XUNPENDED e attending physician for use as the burial AMENDED 23a, 27 per ME g877 3/31/08 amh The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 Yes 2 No 3 ✔ Probably 4 Unknown Completed has been s 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 1 Yes 2 No certificate 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Be Other₄ examiner? Hospital: 1 Inpatient 2 V ER/Outpatient 3 Nursing Home 5 Residence 6 this ٩ 1 🗸 Yes 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 1 X Naturai Yes 2 No Pending within 24 hours after death To the Funeral Director: completely filled in by the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier March 16, 2008 O.C.M.E. Diane Mune 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 8 2008 MAR Registra

OCME 2006

ORIGINAL.

08-01982 Eric Scott Myers Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2	\cap	\cap	0				é
Ľ.	U	U	0	le le		ì	4

		- For State	Certific	ate of l	Death				, No.	m	V IVII
Physicia	n/	Decedent's Name (First, Middle, Last)						Date of Death Month	Dav Yea		Time of Death 1825 hrs
edical Examin		Eric Scott Myers			o. City, Town, or	Location of		March 10, 2	4c. County of	of Death	
	ľ	4a. Facility Name (if not institution, give street and 2643 Sandflat Road	number)	46	Oakland	Location of			Garrett		
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bit	rthday)	If Under 1 Yea		24Hrs. 8	8. Date of Birth 11-03-	(MM/DD/YYYY 1961	Foreign	olace (State or MD
Director		217-78-9454 1 X M 2	₌ 46	Yrs.	Moritins	is Hours	IVIII I.	11-05-	1701	Coun	try)
		Usual Residence of Decedent	10c. City, Town	- or Looptic						1	0d. Inside City Limits
w an)	1	10a. State 10b. County MD Garrett		Lake							1 Yes 2 No
fand fand	ģ				10f. Zip Code			10	g. Citizen of W	nat Countr	y?
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f show any ent, the Medical Examiner must be notified at once.	Director	10e. Street and Number 419 Shendoaha Ave.			2	1550			U.S.A	r	
with t	•		Decedent Ever in U.S.	13. Was	Decedent of H	ispanic Origi	n? (Spec	cify Yes or No-		e - America e, etc.	an Indian, Black,
or iten	Funeral	Never Married 2 Married 1 Ye			X		i deno ra	iodii, oto.,	V	Vhite	
after	by F	3 Widowed 4 Divorced If Yes, Give or Dates:			Yes 2 N	o specify:	ind of wo	rk done	Specify: 16b. Kind of B	usiness/Inc	dustry
hours natur Exam	- G	15. Decedent's Education (Specify only highest	e (1-4 or 5+)	during mo	ost of working lif	e. DO NOT u	use retire	d)	TOD. Paris of Di	101110007111	,
36 in 72 han "	픮	Elementary/Secondary (0-12) Colleg	e (1-4 or 0.1)	Tr	uck Dri	ver			Trucl	cing	
d with	Completed	17. Father's Name (First, Middle, Last)				18.Mother's			Maiden Surname		
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", c event, the Medical Examiner.	Be (Robert W. Myers			_				Campbel:		
more, MD 21215-0036 Pages 1 and 2 should be filed within 7 nent of Health and Mental Hygiene. aut; If item 27 is marked other than or other traumatic event, the Medica	리	19a. Informant's Name/Relationship (Type, Print			Address (Stre				nber, City or To 2933		Zip Code)
MD d 2 sh lith an m 27 i		Phyllis Marie Myers	S 20h Place		Serene I			Date	20c. Location		own, State
or Hea		20a. Method of Disposition 1 Burial 2 XCremation 3 Remove		atory or oth							
Page Page ment c		4 Donation 5 Other Specify:	Omega	Cren	natory				Morga		, WV
Baltimore, MI permit. Pages 1 and 2 s Department of Health at Important; If item 27 injury or other traum	J.	21. Signature of Funer Service I ens	7		lame and Addre						550
		2 a. Part I. Enter the disease, or complications the	at caused the death. Do	not enter th	he mode of dyin	g, such as ca	ardiac or	respiratory am	est, shock, or h		Approximate Interval Between Onset and
Physician /Medical		failure. List only one cause on each line.								9	Death
aminer			as a consequence of):								
		Sequentially list conditions, b									
	ine	cause. Enter Underlying Cause	as a consequence of):								
+	Examiner		as a consequence of):								
ecuted and transi		d									
760, cate be executed physician and the burial - transit	Medical	UNPENDED AMEND							23d. Date	of doliver	
	/Me		yes, outcome of pregnan ive birth	cy っ□ Fe	etal death	3 Ectopi	c pregnar	ncy	Month	_	Day Year
Box 68's death certificate attending and for use as	rsician	past 12 months?	regnant at time of death		ther (Specify)						
m § § §	Physi		Jnknown			a alvenia D		23e Did	tobacco use col	ntribute to	the cause of death?
P.O. es that the igned by oe detach	by P	Part II. Other significant conditions contribu	ing to death but not resu	Iting in the	underlying caus	e given in Pa	art I.				pably 4 Unknown
S, P.C uires that n signed								24a. Was	an 24t		itopsy findings available
ords, w requir as been s	Completed							auto perf	psy ormed?	prior to death?	completion of cause of
Rec The Is cate h	E								2No	1 🗸 Ye	es 2 No
Vital Rec yslcian: The l his certificate director, page	Be	25. Was case referred to medical examiner?		2/0 /		Other;		g Home 5	Residence 6	Othe	r: Scene
of Vital Records, ng Physician: The law requir ther this certificate has been s meral director, page 2 should I	₽	1 Yes 2 No		R/Outpatien		njury at Wor			how injury occ		
C # 7 4 2	ä	1 Natural 5 Pending Ma	Month Day Year)	812 hrs	· · · _	Yes 2 ✓	_	Driver auto	auto collisi	on	
SiO Atten r deatl ector: by the	cati	2 Accident Investigation	. Place of Injury - At hom	e, farm, stre	eet, factory, offic	ce building, e	etc.	28f. Location	(Street and Nu	mber or Ru	ural Route Number, City
Division tal or Attendi us after death. al Director: A	Certification:	3 Suicide 6 Could not be determined	ecify) Local Street					or Town, 2643 Sandfl	State) at Road, Oak	land, MD	
in S in		29a Certifier	a best of my knowledge	death occu	urred at the time	, date and p	lace, and	due to the ca	use(s) and man	ner as sta	ted.
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner:On the	pasis of examination and	or investiga	ation, in my opii	nion, death o	ccurred a	at the time, dat	e and place, ar	a due to tr	
To You	Ĭ,	20h Signature and title of certifier				ense numbe	er -				onth, Day, Year)
		Jane Dre	es		0	C.M.E.			March 1	1, 2008	
		30. Name and address of person who complete	d cause of death (Item 23	3a)	4 D C:	- L D - 14'	one ka	D 24204			
	3		nt Medical Examin		1 Penn Stre	et, Baltim	ore, MI	21201			
S Regis	tate	NEAD 13 2008	32. Registrar's Signature	Louise	11/2 11						

DHMH 17 Rev 1/2001

State

Registrar

CAPSTACK

MAR 1 1 2008

31. Date filed (Month, Day, Year)

egistrar's Signature

2001 MEDICAL PARKWAY, ANNAPOLIS MD 21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25,27,28a-1 per me. 8877,03/26/08dhb

Reg. No. 1 - For State Registral 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MARCH Day 2008 **Physician** MOBERLY HOWARD BRETT 6. 12:24P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yang) Hours Min. Aug. 1.9, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** ^{Year)}950 1 √ M 2 □ F Mary land 57 217-56-2040 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County ns 23a or 28a-f show must be notified at 1 TYes 2XINo Frederick Frederick Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21702 U.S.A. 7116 Autum Leaf Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ※ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "natural", or Items 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after 0 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examiner once. Black, White, etc. Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Musician Music 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marian Rebecca Waterman George Ross Moberly 2 19b. Mailing Address (Street and Number or Aural Aoute Number, City or Town, State, Zip Code) 7116 Autum Leaf Lane, Frederick, MD 21702 19a. Informant's Name/Relationship (Type. Print) Brian K. Moberly, brother 20a. Method of Disposition

XX Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Mount Olivet Cemetery Mar. 10, 2008 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign yury of Funeral Service Lice se Reeney and Bastord PA Funeral Home 106 East Church Street, Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician preymonia /Medical Due to (or as a consequence of) TOWARPROVED BY MEDICAL EXAMINER Examiner MAdriple Sequentially list conditions, it any teach good to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran CERTIFIC Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician s the burial Physician/Medical attending pl for use as t 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 HINknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Domaies 2DNo 2 ☐ ER/Outpatient 3 ☐ DOA 2 s after death.

I Director: After this of in by the funeral d 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Matural Subject passenger in a car strick a felephone pole

28t. Location (Street and Num eco. Bural Toute Number, City or Town, State) Rt 180 near Rt. 5 Pending investigation Spring₁₉₇₈ Unknown 1 ☐ Yes 2 X No 2 Accident 6 Could not be Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide Roadway 340, Petersville, MD e Funeral filled 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D003516 6/2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400 West 7th Street, Frederick, MD 21701 Myung Nam, M.D.,

State Registrar 31. Date filed (Month, Day, Year)

MAR 26

2008

DHMH 17 Rev 1/2001

32. Registrar's Signature

State Registrar 32. Registra Signature

2008

MAR 1

Pouse Ave, D-1, FREDERICK, Mdz1701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Phillips 2008 10:30 p^M May March 13 Cora 4c. County of Death 4b. City, Town, or Location of Death

Funeral Director filed within 72 hours after death with the Maryland ierment of Health and Mental Hygiene. ortant: If Item 27 is marked other then "naturel", or Itema 23a or 28a-f ehow injury or other traumatic event, the Medical Examinar must be notified at Baltimore, Maryland 21215-0036

For State Registrar

Physician

Examin

/Medical

Physician /Medical Examiner

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; Atter this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

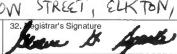
er	Chesapeake Woods Center					Cambridge					Dorchester		
	5. Social Security N 219–42–85		6. Sex 1 □ M 2 K□ F	7. Age (In yrs. la	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Day Mar. 3	v, Year)		Birthplace (State or Foreign Country) Iaryland
tor	Usual Residence of 10a. State	Decedent 10b. County	chester		, Town or Lo		Camk	oridg	e				10d. Inside City Limits 1¾☐ Yes 2☐ No
i Direct	10e. Street and Nur 304 Aca		t. Apt. 2	03		10f. Zip	Code	2161	3		10g. Citiz	usa USA	Country?
Be Completed by Funeral Director	11. Marital Status 1 □ Never Marri 3 🌁 Widowed		ried Armed For 1 ☐ Yes If Yes, Giv	2 XNo e		Was Deced If Yes, spec		ispanic Or in, Mexical Specify:		ecify Yes or No Rican, etc.)		Black, W	merican Indian, hite, etc. white
mpleted I	Elementary/Seco	ify only highe	nt's Education est grade completed) College (1		16a. Dece (Give life.	dent's Usua kind of wor DO NOT us home	rk done d se retired	during mos ()	st of work	ing		nd of Busine	
To Be Co	11 17. Father's Name Charle		Schaffer							e (First, Middle, Martha			
_	19a. Informant's Na Cora Lee	Mowbr				Academ	ny St		t. 3	al Route Number 03, Cam	brid	ge, MI	
	4 Donation	☐ Cremation 5 ☐ Other (5		Ci Ci	emetery, cres cheste	matory or or er Men	ther place	ark	3/19	/08	Cam	bridge	e, MD
	21. Signature of Fu	4. Ilo	mer		1	700 Lc	cus	t St.	, Ca	omas Fu mbridge	, MD		
	resulting in death) Due to (or as a consequence of):											Interval Between Onset and Death 2 months	
Physician/Medicai Examiner	Sequentially list conditions D.										nogeas		
ysician/Me	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 9 Unknown	months?	1 Live b	come of pregna irth 2 ☐ Feta ant at time of d own	Ideath 3	⊒Ectopic pr ⊒ Other (sp						23d. Date of Month	delivery Day Year
by			tions contributing to de	dr			ause giv	en in Part	l.				e to the cause of death? Probably 4 Unknown
Completed			-									prior deatl	autopsy findings available to completion of cause of h? Yes 2 \(\sumbolearrow\) No
Be	25. Was case reference examiner?	rred to medic					Oth			th (Check only			
ion: To	1 ☐ Yes 2 ☐ 27. Manner of Dea 1 ☑ Natural	th 5 ☐ Pend	ling 28a. Date (Mon		28b. Time of Injury		28c. Injur Wor	4 14		ome 5 ☐ Res 28d. Describe			Specify)
Medical Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide									28f. Location (City or To			r Rural Route Number,
dical C	29a. Certifier (Check only one)	1 Certify 2 Medica	ring Physician: To the al Examiner: On the b and man	best of my kno asis of examina ner stated.	owledge, dea ation and/or i	th occurred nvestigation	at the tiin, in my c	me, date a opinion, de	and place eath occu	, and due to the rred at the time	date an	d place, and	due to the cause(s)
Me	29b. Signature and	pan	son d	N				0 5		73		81.111	Ipnth, Day, Year)
	30. Nume and add	ia c	on who completed cause of the solution of the	100	Bro	Rint)	le	Ca	mb	73 ridge	M	0	21613
ite	31. Date filed (MO)	MAR	1 7 2008	Jan 3 Sight	M	American	de a						

DHMH 17 Rev 1/2001

State Registrar

Registrar

31. Date filed (Month, Day, Year) MAR 1 7 200



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🚄 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 1:00 PM Billie Mae Porter 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Plata ical 4 Hrs. 8. Date of Birth
Min. (Month, Day, Year)
April 29, 1920 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days 1 □ M 2 🖫 F 465-44-2549 87 Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show at be notifled 1 ☐ Yes 2 ☑ No Director MD Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 6415 Ocelot Street 20603 USA 'natural", or items 23a dical Examiner must ! Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home permit. Pages 1 and 2 should be filed I Department of Health and Mental Hygis Important: If Item 27 is marked other any injury or other traumatic event, <u>tt</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Ray DeWiees Martha Beatrice DeRocco 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine Greene/Daughter 6415 Ocelot Street, Waldorf, MD 20603 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 Removal from State Maryland Veterans Cem. 3/24/2008 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee ²²AREHARI ECHOLS FUNERAL HOME, P.A. M00945 School au 211 St. Mary's Ave. La Plata, MD 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** neumo ma /Medical Due to (or s a consequence of): Trock Infect Examiner 1 remain sendomonas Sequentially list on dillons, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed action and Due to (or as a consequence of): burial P.O. Box 68760. physician Physician/Medical the IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown signed to eath but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ Dest 2 No 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed certificate 1 2/2 No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 20 No 1 🔲 Yes Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 1 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifylng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To th. within 2. To the Fu and manner stated. 29b. Signature and title of pertifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Nem 23a) (Type, Print)

Road But 208A

20602

T		1- For State Registrar		Certificate (R	leg. No.	10 Time (50 - 10
			•		Desc et		Month	Day Year	3. Time of Death 1810 hrs
Exami									
					Bowie				
uneral		Social Security Number 6.	Sex 7. Age (In y	rs. last birthday)				rth(MM/DD/YYYY)). Birthplace (State or or oreign Maryland
rector		216-80-6888	X M 2 F 47	١		Days Hours	Min. 01/2	26/1961	Country)
		Usual Residence of Decedent							
v any	ı	10a. State 10b. County	10c. (•					10d. Inside City Limits 1 X Yes 2 No
f sho	ō	Maryland Princ	e George						
r 28a-	e C	10e. Street and Number			10f. Zip C		[Country?
23a o	اق								in the Disale
tems it be	Jera		Armed Forces?						American Indian, Black, etc.
r or	Ξ	Parameter of State and Sta	1 A Yes 2 N		Ves 23	No specify:		N a	ative American
ural*	þ		only highest grade complete	d) 16a. Deced		*	nd of work done		
"nat	ec	Elementary/Secondary (0-12)	College (1-4 or 5+)		most of working	ng life. DO NOT u	se retired)		
ne. r than	du	12		Pain	nter			Self-e	mployed
Tygie other the M	Ŝ		st)			18.Mother's	Name (First, Middle,	Maiden Surname)	
irked rent,	Be	John Ma	ırsenia						Harley
nd Me is ma ufic ev	욘								
alth a m 27 aum			/ Sister						
of He If ite						or cemetery,	Date		
ment tant: or of				Marylar	nd Vet	erans 3	3/31/08		ham,Marylan
Depart mpor njury		21. Signature of Funeral Service Lic	ensee	9.00					
		23a Part I For the disease or ca	enlications that caused the d						
sician edical		failure. List only one cause on	each line.						Between Onset and Death
miner		Immediate Cause (Final disease or condition resulting in death)			ng Bleed	Esophagea.	Varices		
		Sequentially list conditions	b.						
	ner	if any, leading to immediate	Due to (or as a consequen	ce of):					
	ami	(Disease or injury that initiated	C. Due to (or as a consequen	ce of):					
d ansit	ŭ								
an an al - tr	ical	X UNPENDED	AMENDED 23a, Pt.	II,27,28a-	f per M	E g879 5/2,	/08 amh		
hysici e buri	sician/Medical E	IF FEMALE:	23c. If yes, outcome of	pregnancy				23d. Date of d	elivery
교육	an/I	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2	Fetal death	3 Ectopic	pregnancy	Month	Day Year
ling	sici	1 Yes 2 No 9 Unknow	4 Pregnant at time o	of death 5	Other (Specif	ý)		İ	
attending or use as		Lance Control of the	9 Olikilowii	not resulting in th	e underlying c	ause given in Par	t I 23e, Did	tobacco use contrib	ute to the cause of death?
y the attending physician and thed for use as the burial - tran	ڳ کلا		Continuoung to death but i	not resulting in th	ie underlying c	adde green in r di			Probably 4 V Unknown
ned by the attending detached for use as	Phy	Part II. Other significant condition					Total Control	Income.	
en signed by the attending	Phy	Chronic Alcoholis	an					s an I 24b. W	ere autopsy findings available
as been signed by the attending 2 should be detached for use as	Phy	-	an					opsy pri	or to completion of cause of
cate has been signed by the attending	Phy	-	au -				auto	opsy pri formed? de	
certificate has been signed by the attending xtor, page 2 should be detached for use as	Completed by Phy	Chronic Alcoholis 25. Was case referred to medical	Heroital			5.Place of Death (auto period 1 Yes	opsy pri formed? de 2 No 1	or to completion of cause of ath? Yes 2 No
r this certificate has been signed by the attending al director, page 2 should be detached for use as	Be Completed by Phy	Chronic Alcoholis 25. Was case referred to medical examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2		ent 3 DO	Other	auto per 1 Yes Check only one) Nursing Home 5	propsy priformed? de 2 No 1 Residence 6	ath? ✓ Yes 2 No Other: Scene
After this certificate has been signed by the attending funeral director, page 2 should be detached for use as	To Be Completed by Phy	Chronic Alcoholis 25. Was case referred to medical examiner? 1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day, Year)	28b. Time	ent 3 DO	Other 4	auto per 1 Yes Check only one) Nursing Home 5 28d. Describe	priformed? de 2 No 1 Residence 6	or to completion of cause of ath? Yes 2 No Other: Scene
death. ctor: After this certificate has been signed by the attending y the funeral director, page 2 should be delached for use as	To Be Completed by Phy	Chronic Alcoholis 25. Was case referred to medical examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day, Year) Find 3/22/08	28b. Time	ent 3 DO of Injury 28	Other 4 Other	auto per 1 Yes Check only one) Nursing Home 5 28d. Describe Subject	Pesidence 6 Fell	or to completion of cause of ath? Yes 2 No Other: Scene
after death. Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use as	To Be Completed by Phy	Chronic Alcoholis 25. Was case referred to medical examiner? 1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Pending 1 X Accident Investig 3 Suicide 6 Could no	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day, Year) Find 3/22/08 28e. Place of Injury -	28b. Time Find 5:4	ent 3 DO of Injury 28	Other 4 Other	auto per 1 Yes Check only one) Nursing Home 5 28d. Describe Subject 28f. Location or Town.	posy priformed? 2 No 1 € Residence 6 ✓ e how injury occurred Fe11 (Street and Number State)	or to completion of cause of ath? Yes 2 No Other: Scene
nours after death. neral Director: After this certificate has been signed by the attending filled in by the funeral director, page 2 should be detached for use as	Be Completed by Phy	Chronic Alcoholis 25. Was case referred to medical examiner? 1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Pending Investig. 2 X Accident Investig. 3 Suicide 6 Could not determine	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day, Year) Find 3/22/08 28e. Place of Injury - (Specify) Residen	Fnd 5:4 At home, farm, s	ent 3 DO of Injury 28 46p treet, factory, 6	Other, Ot	autoperior	Residence 6 Resid	or to completion of cause of ath? Yes 2 No Other: Scene or Rural Route Number, City idge Rd Bowie MD
After this certificate has been signed by the funeral director, page 2 should be detached for	To Be Completed by Phy	Chronic Alcoholis 25. Was case referred to medical examiner? 1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Pending Investig. 2 X Accident Investig. 3 Suicide 6 Could not determine the monicide Centrol of the country of the countr	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day, Year) Find 3/22/08 28e. Place of Injury -	Fnd 5:4 At home, farm, s	ent 3 DO of Injury 28 46p treet, factory, occurred at the t	Other Condition of the	autoper 1 Yes Check only one) Nursing Home 5 28d. Describe Subject 28f. Location or Town, 17211 Que, and due to the ca	Residence 6 Resid	or to completion of cause of ath? Yes 2 No Other: Scene or Rural Route Number, City idge Rd, Bowie, MD as stated.
	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23n or 28a-f show any can be injury or other traumatic event, the Medical Examiner must be notified at once.	Department of Health and Mental Hygiene. Journal of Health and Mental Hygiene. Journal of the posture of the transmatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	1. Decedent's Name (First, Middle, La Frederick 4a. Facility Name (if not institution, gardent of the product	Thysician The condition The condition	Nysician 1. Decedent's Name (First, Middle, Last) Frederick Desmond	Thysician Products Name (First, Middle, Last) Frederick Desmond Proct 4a. Facility Name (if not institution, give street and number) 17211 Queen Anne Bridge Road 5. Social Security Number 6. Sex 7. Age (in yrs. last birthday) 17211 Queen Anne Bridge Road 5. Social Security Number 6. Sex 7. Age (in yrs. last birthday) 17211 Queen Anne Bridge Road 182	Thysician Thys	Neglistrar Neg	December New Name (First, Middle, Last) Desmond Proctor 2 Date of Death March 22, 2008 March 22, 2008 Prince Ger 3 As Facility Name (First, Middle, Last) Proctor As Facility Name (First, Middle, Last) Prince Ger 3 As Facility Name (First, Middle, Mailer Surame) Prince Ger 3 As Facility Name (First, Middle, Mailer Surame) Prince Ger 3 As Facility Name (First, Middle, Mailer Surame) Prince Ger 3 As Facility Name (First, Middle, Mailer Surame) Prince Ger 3 As Facility Name (First, Middle, Mailer Surame) Prince Ger 3 As Facility Name (First, Middle, Mailer Surame) Prince Ger 3 As Facility Name (First, Middle, Mailer Surame) Prince Ger 3 As Facility Name (First, Middle, Mailer Surame) Prince Ger 3 As Facility Name (First, Middle, Mailer Surame) Prince Ger 3 As Facility Name (First, Middle, Mailer Surame) Prince Ger 3 As Facility Name (First, Middle, Mailer Surame) Prince Ger 3 As Facility Name (First,

Assistant Medical Examiner Theodore M. King, Jr., MD. State 31. Date filed (Month, Day Year) MAR 2 5 2008 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

ORIGINAL

OCME

111 Penn Street, Baltimore, MD 21201

O.C.M.E.

March 23, 2008

Registrar

08-02185 Charles Puskar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

r")	17	\Box	\bigcirc	1.0	10
6	U	0	Ü	1.0	12

nanes ruskai		1- For State Certificate of Death	h	Reg. N	No.	
Physician		Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death Month Da	y Year	3. Time of Death 1810 hrs
le 🦈 🥄 Examine		Charles James Puskar, II	own, or Location of De	March 18, 20	4c. County of Death	
	4	4a. Facility Name (if not institution, give street and number) Howard County General Hospital 4b. City, T Colum			Howard	
Funeral	5	5. Social Security Number 6. Soci	er 1 Year If Under 24		MM/DD/YYYY) 9. Bir	n l
Director		577-86-6122 1 M 2 F 46 Yrs. Months	s Days Hours	Min. 02/28/1	.962 co	untry) MD
any	_	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
* .	ا ي	MD Prince George's Suitland				1 Yes 2 X No
Aaryland 28a-f show 1 at once.	Director	10e. Street and Number 10f. Zip	Code		Citizen of What Cou	ntry?
th the Maryland 23a or 28a-f sho notified at once		3811 Walls Lane	20746		U.S.A.	ican Indian, Black,
hours after death with the Maryland natural", or items 23a or 28a-f shu Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent fyes, specification of the control of th	ent of Hispanic Origin? fy Cuban, Mexican, Pu	(Specify Yes of No- lerto Rican, etc.)	White, etc.	ican indian, black,
er deat	키	1 Yes 2 X No 3 Widowed 4 X Divorced If Yes, Give Year 1 Yes 2	No specify:		Specify: Whi	te
5-0036 ted within 72 hours after other than "natural", the Medical Examiner	┋├	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual	Occupation (Give kind		6b. Kind of Business	Industry
24 3 -	ete 	Elementary/Secondary (0-12) College (1-4 or 5+)	rking life. DO NOT use	e retired)		
036 Aithin and and and and and and and and and an	Completed		mployeed	Name (First, Middle, Ma	Masonar	У
15-003 filed within Hygiene. d other th	ပ္တို	17. Father's Name (First, Middle, Last) Charles James Puskar, I		Joan Spend		
e a de la	To Be	19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address	s (Street and Numbe	er or Rural Route Number	er, City or Town, Stat	e, Zip Code)
O sh and sh o				dgewater, M		7 000
e, M 1 and 2 Health Fitem 2		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Na crematory or other place	e)		20c. Location - City o	
More Pages 1 ient of P unt: If i		Lee Cremator		03/25/2008		
Baltimore, permit. Pages I a Department of He Important: If ite injury or other tr	Ī	21. Si al re of Funeral Service Licensee 22. Name and	d Address of Facility	ee Funeral Blvd. Ow	Home Caly	ert P.A.
	4	23a. Part I. Enter the disease, or conclications that caused the death. Do not enter the mode	outhern Md of dying, such as card	diac or respira ory arres	ings MD 4 t, shock, or heart	Approximate interval
Physician //edical		failure. List only one cause on each line.				Between Onset and Death
_xaminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):				
		Sequentially list conditions, b				
	<u>i</u> je	if any, leading to immediate cause. Enter Underlying Cause				
r sit	Examine	Cities ase or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed him 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and implietly filled in by the funeral director, page 2 should be detached for use as the burial - transit	등	d. XX unpended X amended 23a,Pt II,27,28a-f per	ME g878 4/4	/08 amh 1 per	ME G878 4/7	/08 amh
60, ate be e	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy	· ·		23d. Date of delive	ery
3876 rtifical ing ph	an/	23b. Was decedent pregnant in the past 12 months?		oregnancy	Month	Day Year
Box 687 The death certifice the attending part of for use as the form of the	sician/	4 Pregnant at time of death 5 Other (Sp	pecify)			
the de by the ched fiched f	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying	ng cause given in Part			to the cause of death?
P.C es that igned be deta	ą	Atherosclerotic Cardiovascular Disease		1 Yes	Mark Commence of the Commence	robably 4 V Unknown
rds, requir been s	Completed			24a. Was a autops	y prior t	autopsy findings available o completion of cause of
ecol	E C			perform 1 ✓ Yes 2		
NII. TI	انت	25. Was case referred to medical	26.Place of Death (C			
Vita hysici hysici hysici l direc	8 9	1 Ves 2 No Impatient 2 ENGUIDATION OF			Residence 6 Ot ow injury occurred	her:
n of ing Pl After funera	Ë	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work?		OW HIJULY COCCINGO	2110
Sior Nttend death death sctor:	catic	Pending 2 Accident St. Pending 3/18/08 Find at 5:00pn Investigation 28e. Place of Injury - At home, farm, street, factor	ni —		treet and Number or	Rural Route Number, City Brook Dr.
Division of Vital Records, P.O. real or Attending Physician: The law requires that the react cleath. Al Director: After this certificate has been signed by the funeral director, page 2 should be deach.	Certification:	3 Suicide 6 X Could not be determined (Specify) Residence		or Town, St	ate)/356 Eden MD	Brook Dr.
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as the			the time, date and place	ce, and due to the cause	e(s) and manner as s	tated.
o the lithin 2 o the l	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.	my opinion, death occ	curred at the time, date a	and place, and due to	trie cause(s)
To with To Con.	Me	1 1	29c. License number		29d. Date signed (March 19, 200	
		Jasha Geelg nis	O.C.M.E.		WIGHT 15, 200	
		30. Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner 111 Penr	n Street, Baltimor	re, MD 21201		
	ate	Tabila dicellacing inst				
Si Regist		MAD 2 / 2008 Strategy OF SHOWING				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

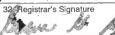
			State of Maryland / Department of Hear 1 - State Penietrar Certificate of De			- LU	08 10122
			1 - State Registrar Certificate of De	Jain	2. Date of Deatl	g. No.	3. Time of Death
	Physicia	an			Month	Day	4:45 P M
	/Medic		Mary Bounds Pilchard 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Lot		March 1	4c. County of	
	Examin	er		ke City		Worces	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If	f Under 24 Hrs.	8. Date of Birth (Month, Day,		9. Birthplace (State or Foreign
	Director		216-09-6154 1□ M 21∆ F 99 Yrs. Months Days F	Hours Min.	Jan. 16,	1909	Maryland
	P		Usual Residence of Decedent				10d, Inside City Limits
	arylaı show d at	-	10a. State 10b. County 10c. City, Town or Location				1 X Yes 2 No
	he M. 8a-f. otifie	Director	MD Worcester Pocomoke City			og. Citizen of W	hat Country?
	with t	늅	10e. Street and Number Hartley Hall Nursing Home		"		
	eath ns 23 must	era	1006 Market Street 21851 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hisps	anic Origin? (Spe	ecify Yes or No-	U . S .	• A •
	fter d r iten iner	Funeral	Armed Forces? If Yes, specify Cuban, I 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No □ □	Mexican, Puerto	Rican, etc.)		, White, etc.
2000	urs a al', o	by	If Yes, Give 1 ☐ Yes 21公 No S 3 ☑ Widowed 4 ☐ Divorced Year or Dates:	Specify:		Specify:	white
ָרָ ה	72 ho natur lical I	Completed	15. Decedent's Education 16a. Decedent's Usual Occupatio (Specify only highest grade completed) (Give kind of work done duri	on ina most of worki		16b. Kind of Bus	siness/Industry
7	ithin ne. nan "	npje	Elementary/Secondary (0-12) College (1-4or 5+)			. 1	C 71
7	led w lygier her th	ပ်	1 bookkeeper	9 Mothor's Name	e (First, Middle, N		of Education
/land	be fil d oth	Be	,			ialueri Surname	=)
Ž	d Mer d Mer narke	욘	William J. Bounds 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and	Ella Pu		City or Town	State Zin Code)
<u>0</u>	d 2 s th an th an 17 is r traun		Janet Bounds Carter (Niece) 103 S. Bay Stre		ow Hill		1863
ก	Heal Heal tem 2		20h Place of Disposition	; [City or Town, State
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Cemetery, crematory or other place) Snow Hill Christian Church Cemetery	n ¦	17 2008	Cnorr L	Hill, Maryland
altimor	nit. F sartm ortar injur		21 Signature of Funeral Service Licensee 22. Name and Address of	of Facility		SHOW I	alli, Marylanu
ŏ	Der Jany any	9	Short Funer 13 E. Grove	ral Home e Street	Delma	ar, DE	19940
	5 -10		23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, s	such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician	3 17	Immediate Cause (Final disease or condition Oronary Athero	sclero	th'S		Onset and Death
	/Medical		resulting in death) Due to (or as a conseq (er ce of):				
	Examiner		Sequentially list conditions, b.		_		
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				
	xecut and II-tran	xan	that initiated events resulting in death) Last				
8/00,	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the buriar-transit						
00	ficate p physis the	edical	0.		-		
X O O	nding use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy			23d. Date	e of delivery
ם	death e atte d for	icia	in the past 12 months? 1			Mor	nth Day Year
5	at the by the tache	hys	9□Unknown				
'n	es the	by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given i	in Part I.			ibute to the cause of death?
5	equir	ted			1 🗆 Ye	es 2 No	3 Probably 4 □Unknown
Hecords	law ras be	Completed			24a. Was a autops	v D	Were autopsy findings available prior to completion of cause of
	The	Con			perform 1 Yes	ned? 2 No 1	leath? □Yes 2☑No
V II a	ician sertifi ector,	Be	examiner? Hospital: Other:		h Check onl on	F of	
0	Physical this call direct	၉	1 Inpatient 2 EH/Outpatient 3 DOA	4 Law Nursing Ho	ome 5 Reside		
	ding I	ion	1 Natural 5 Pending (Month, Day Year) Injury Work?	s 2 □ No	Zod. Describe in	ow rightly booking	
UNISION	death death ctor: y the	ical	3 Suicide 6 Could not be		28f. Location (Si	reet and Numbe	er or Rural Route Number,
2	after after Dire	Certification:	4 ☐ Homicide determined building, etc. (Specify)		City or Town	n, State)	
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time,	, date and place,	and due to the c	ause(s) and ma	nner as stated.
	he Ht in 24 he Ft pletel	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opin and manner stated.				
	To t To t	Ž	29b. Signature and title of certifier 29c. License n	number	_ 2		(Month, Day, Year)
,	h		SARAD R. BARAL, MD D5	54425	2	03-	13-2008
	MA		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	d 218	51		
			31 Date filed (Month Day Year) 32. Broistrar's Signature	2 00	·		
	Sta Registi		MAR 1 7 2008				
211		001	1 1000000000000000000000000000000000000				

			For	State of Maryland /	Depa	artment of H	lealth and l	Mental Hy	giene		
			for State Registrar		Cei	rtificate of	Death		Reg. No. 2	008	10123
	(B)-	é –	1. Decedent's Name (First, Middle,	Last)				2. Date of Dea	ath Day	Year	3. Time of Death
	Physicia Medic		MARGARET	D RAMSBURG				MARCH	~ ~	2008	4:15 P M
	Examin		4a. Facility Name (If not institution,	give street and number)		4b. City, Town, o	r Location of Deatl	h	4c. Coun	nty of Death	
-	(1)			MEMORIAL HOSPITAL 6. Sex 7. Age (In yrs. last		FREDI	ERICK If Under 24 Hrs.	8. Date of Birt	h	REDERI	CK place (State or Foreign
	Funeral Director		214-46-6029	1 M 2 M F 95	Yrs.	Months Days	Hours Min.	(Month, Da)	y, Year)	Cour	rinia
			Usual Residence of Decedent					11/11/	1)12		
	irylan show	lan.	10a. State 10b. County	10c. City, To	own or Lo	cation				1	0d. Inside City Limits 17 Yes 2 No
	Ba-f s	Director		erick	Fr	ederick			10g. Citizen o	of What Coul	
	with the		10e. Street and Number			10f. Zip Code 21701	1		United	_	
	be filed within 72 hours after death with the Maryland tial Hygiene. do other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	308 Rockwell To	12. Was Decedent Ever in U.S.	13.	Was Decedent of H If Yes, specify Cubi		Specify Yes or No		ace - Americ	can Indian,
٥	after o		1 ☐ Never Married 2 ☐ Marrie	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give		ir Yes, specity Cub: 1 □ Yes 2 X No		to Hican, etc.)	1	slack, White, cify: whi	
2-00-c	ural", c	d by	3 Widowed 4 □ Divorced	Year or Dates:					'		
ה	"natu	lete	15. Decedent (Specify only highes		6a. Deced (Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wo d)	rking	16b. Kind of	Business/In	dustry
Z	withir ene. than than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		memaker	~/		own 1	home	
D	filed Hygi other ent, tl	Be C	17. Father's Name (First, Middle, I	1 7	1.0	шешакет	18. Mother's Nar	me (First, Middle,			-
land	uld be Mental rrked c	To B	Daniel T. Duti					Maude St			
lar)	2 should and Men is marke aumatic		19a. Informant's Name/Relationsh			ng Address (Street					
()	ges 1 and 2 should t of Health and Mer If item 27 Is marke or other traumatic	9	Dorothy R. Thom 20a, Method of Disposition			Luxor To		Date	sville 20c. Location		22901 nwn. State
	Pages nent of h		1 ☐ Burial 2 ☐ Cremation	3 ☐ Removal from State	-	osition (Name of matory or other pla		rch		•	
Sartimor		1 8	4 □ Donation 5 □ Other (S _k 21. Signature of Funeral Service I	DILL OI.	ısbur 2	g Cremato 2. Name and Addre	ory : 42	onovi & B	Smith	sourg,	Maryland
n	permit. Departr Imports any inj	. 3	pagulin 4	MO1222	1	.06 East (Church S	treet. F	rederi	ck, MI	21701
П			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused the death. It	Do not en	ter the mode of dyi	ng, such as cardia	c or respiratory a	rrest,		Approximate Interval Between
	Physician	0 5	Immediate Cause (Final disease or condition	Conges	Tiv-	e Hear	t fa	Nune			Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a consequent	ce of):	1					70100
	Examiner	7.0	Sequentially list conditions,	b. Die to (or es a romandiene	ce of	7212					and the
	uted I Insit	Examine	Sequentially list conditions, if any, is amy to minimize the cause. Enter Underlying Cause (Disease or injury that initiated events								
ב	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a consequen	ce of):						
2/60	ate be nysicia he bu	dical		d							
Õ	ertifica ing ph e as th	Med	IF FEMALE:	00. 1/							
gox	attend attend for us	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 █ No	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deatl	eath 3	☐Ectopic pregnanc☐Other (specify) _	·y			Date of deliv Month	ery Day Year
o.	the de	ysic	1 □ Yes 2 No 9 □ Unknown	9□Unknown	11 01						
7.	w requires that the death certific been signed by the attending p should be detached for use as:		Part II. Other significant condition	ns contributing to death but not resulting	ng in the u	nderlying cause giv	ven in Part I.	23e. Did i	tobacco use co	ontribute to	the cause of death?
g	quires en sign uld be	ed by	cerehr	osasuer a	CC	- I dut		1 🗆	Yes 2.	Pro 3□ Pro	bably 4 □Unknown
ပ္ပ ပ	aw re as bee 2 sho	Completed	Pacin	atra				24a. Was		b. Were aut	opsy findings available ompletion of cause of
ř	The law ate has b page 2 st	E O						perfe 1⊟ Yes	ormed? 2ENo	death? 1 ☐ Yes	2□No
Vital Records,	sician: The law certificate has b irector, page 2 s	Be	25. Was case referred to medical examiner?	I to a state of		low		eath Check onl	one		
o	Physi this c	2	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Impatient 2 ER. 28a. Date of Injury 28	Outpatie	III JUDOA		Home 5 ☐ Res 28d. Describe			ify)
	ding la. After funer	tion	1 Natural 5 ☐ Pendin	(Month, Day Year)	Injury	Wo	rk?]Yes 2∐No	25d. Besonbe	mon many oo	341104	
UIVISION	Atten r deat sctor: by the	fica	3 Suicide 6 Could r	ot be 28e. Place of injury - At home	e, farm, st	reet, factory, office		28f. Location (Street and Nu wn, State)	ımber or Rui	ral Route Number,
5	s after	Certification:	4 Homicide	building, etc. (Specify)			_	Only of 10	wii, State)		
	Hospit Hour Uners	edical (29a. Certifier .1 Certifyin	g Physician: To the best of my knowle Examiner: On the basis of examination	edge, deat n and/or ir	th occurred at the t nvestigation, in my	ime, date and place opinion, death occ	ce, and due to the curred at the time	cause(s) and , date and plac	manner as ce, and due	stated. to the cause(s)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,	Medi	one) 29b. Signature and title of certifier	and manner stated.	-	29c. Licen			29d. Date sig		
	7 × 9 8		25b. Signature and the or certifier	·P			09689	j	3/2	5/01	2
			30. Name and address of person	who completed cause of death (Item 23	Ba) (Type.		- 100	•	,		O
				Pearre, Jr. / 300			eet, Fre	derick,	MD 217	01	

State Registrar 31. Date filed (Month, Day, Year)

MAR 2 8 2008

32. Registrar



forti

		For State Registrar	State	of Marylar				lealth and Death	Mental Hy	giene Reg. No.	200	8 10124
Dharist		1. Decedent's Name (First, Middle							2. Date of De		Year	3. Time of Death
. Physicia /Medic		Donald Leon	n Ripley						MAI		Q, Year	
Examin	er	4a. Facility Name (If not institution Saint Jose	n, give street and r ph Medi	oumber) cal Cer	nter	4b. City	r, Town, or	Location of Dea	th SON	4c. C	County of De Ba	ath ltimore
Funeral		5. Social Security Number	6. Sex 1 2X M 2 ☐ F	7. Age (In yrs.		If Unde Months	r 1 Year Days	If Under 24 Hr Hours Mir	1. (Month, D	ay, Year)		Irthplace (State or Foreign Country)
Director		214-32-4871	1 2201 2	73	115.				Nov 0	9 193	4	MD
and and	ŀ	Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation						10d. Inside City Limits
/aryl	5	MD Car	17		ToTo out-							1 ☐ Yes 2 ☐ No
the 1 28a-	Director	10e. Street and Number	roll		West	$\overline{}$	p Code	***		10g. Citize	en of What C	Country?
with the tree		1100 Spring	view Lane	2			21	158			USA	
ns 2; mus	Funeral	11. Marital Status	12. Was De	ecedent Ever in U	I.S. 13.	Was Dec			Specity Yes or Norto Rican, etc.)		4. Race - Am	nerican Indian,
of the control of the		1 ☐ Never Married 2 ☐ Mar	ried 1 XYes	5 21 1190	30	if Yes, sp 1 ☐ Yes			erto Rican, etc.)		Black, Wh	
O3(þ	3 XWidowed 4 ☐ Divorced	If Yes, (Year or	Dates: 19	59	1 1 163	2140	Specify:				White
21215-0036 d within 72 hours af giene. er than "natural", or the Medical Exam	Completed	15. Deceder (Specify only highe	it's Education st grade complete	al)	16a. Dece	kind of w	ork done o	durina most of w	orking		d of Busines	s/Industry ounty Board
rithin and and and and and and and and and an	ď	Elementary/Secondary (0-12)		(1-4or 5+)	life.		use retired	0			ducati	
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. wher then "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	$\bar{\delta}$	17. Father's Name (First, Middle,	Last)			Teac	her	18 Mother's N	ame (First, Middle			
ed albe	Be	Mark J. Riple							garet Flo		,	
aryla should and Men s marke umatic	은	19a. Informant's Name/Relations			19b. Mailii	ng Addres	s (Street		Rural Route Numi		Town, State	, Zip Code)
y, Mar and 2 sho saith and n 27 is m		Debbie Wilson/										21158
o – ∓ ₽ ₽		20a. Method of Disposition	augircei.	20b. I	Place of Dispo cemetery, cre	osition (Na	ame of	not koar	1_Westm /1572008	20c. Loc	ation - City of	or Town, State
Baltimore, permit. Pages 1 ar Department of Hea Important: If Item any Injury or other		1X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		m State I				1 Garder		F	inksbu	rq, MD
mit. I		21. Signature of Funeral Service							ome and (
B a m Be		VK.CE	pur	6	4	112 W	<i>l</i> ashii	ngton Ro	oad West	tminst	ter, M	D 21157
Physician		23a. Part1. Enter las isease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition		t caused the dea each line.					ac or respiratory	arrest,		Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death)		to (or as a consec RDIAC F								1 HOUR
	je.	Sequentially list conditions,	b. Dust	o (ur de a consuc	(uerice of):							
ray 60, cate be executed ohysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	to (or as a consec	quence of):							
Hecords, P.O. Box 6 The law requires that the death certific te has been signed by the attending p age 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1⊡Liv	outcome pf pregn e birth 2 Feta egnant at time of d known	aldeath 3[⊒Ectopic ⊒ Other (s	pregnancy specify)	,		23	3d. Date of d Month	lelivery Day Year
VITAI HECOTGS, P. stalan: The law requires that the certificate has been signed by rector, page 2 should be detacted.	ρ	Part II. Other significant conditi	ons contributing to	death but not res	sulting in the u	ınderlying	cause giv	en in Part I.			e contribute	to the cause of death? Probably 4 Unknown
v requestions	Completed							44	24a. Wa	s an	24b. Were	autopsy findings available
he lav ge 2	dm								- auto	opsy formed?	prior to death	o completion of cause of
- 10 1		25. Was case referred to medica						26 Place of D	1□ Yes eath Check onl		1 □ Y	es 2 No
	o Be	examiner?	Hospital:	Inpatient 2	ER/Outpatie	nt 3∏ [Oth	or:	Home 5□Res		□Other (Si	pecify)
g Physer this eral di	n: To	27. Manner of Death	28a. Da	te of Injury	28b. Time o		28c. Injur Wor		28d. Describe			
ndlng ath. r. Afte	atio	1 Natural 5 □ Pendii 2 □ Accident invest	ng (M gation	onth, Day Year)	Injury	М		Yes 2 □ No				
To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	ained 200. Flo	ice of injury - At h ilding, etc. (Speci	nome, farm, st ify)	reet, facto	ry, office		28f. Location City or To	(Street and own, State)	Number or	Rural Route Number,
e Hospit 24 hour e Funera letely fille	Medical (29a. Certifier 1 Certifyi (Check only one) 2 Medica		the best of my know basis of examination	owledge, deal ation and/or ir	th occurre	d at the til	me, date and pla opinion, death o	ice, and due to the courred at the time	e cause(s) e, date and	and manner place, and d	as stated. lue to the cause(s)
To th Within To th	Me	29b. Signature and title of certific	er A			2	9c. Licens	e numb <i>e</i> r		29d. Date	signed (Mo	onth, Day, Year)
1152) [[\a	Jh 6.18	liter			DEQ	2142		31	11/0	8
15tINA	ŀ	30. Name and address of person	who completed ca	ause of death (Ite	m 23a) (Type,	, Print)						
15 (,		MARK G. MID				RDR	IVE	TOWSON	, MARYL	AND	2120	4
× Sta	te	31. Date filed (Month, Day, Year		. Regiatrar's Sign	ature							

Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 8.30 AM ROSPS TO 2008 KILHARD MARCH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** HAKBOR HOSPITAL BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 □ F 578-52-8631 Director 68 DEC 13, 1939 WASHINGTON, D.C. Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Director MARYLAND PRINCE GEORGE'S LANHAM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9908 LANHAM SEVERN ROAD 20706 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) MANAGER EXTERMINATOR d 2 should be filed w th and Mental Hygier 7 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked any injury or other traumatic ew JOHN W. ROBERTS, SR. MARY SHANAHAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DONNA R. ROSADO/DAUGHTER 3706 5TH ST., BALTIMORE, MD 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) METROPOLITAN CREMATORY 3/9/2008 ALEXANDRIA, VIRGINIA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ROBERT E. EVANS FUNERAL HOME, 16000 ANNAPOLIS ROAD, BOWIE, MARYLAND 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metastatic /Medical Due to (or as a consequence of): 5 month Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last iner Due to (or as a consequence of): burial-transit Exami Due to (or as a consequence of) Box 68760, attending physician pe Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) been signed by the s 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has be 2 s autopsy page performe certificate 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 2 this After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

P.0. Division or Vital Records, hours

To the Funeral Director: To the Hospital within 24

State

Registrar

Medical

al 31. Date filed (Month, Day, Year)

29a. Certifier

(Check only one)

29b. Signature and title of certifier

29c. License number 001

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Balkmale HANOVER ST, HARDON HOSPITCH 3001

MAR 1 3 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Crenia Lucille Robbins 2008 March 13 10:10 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mallard Bay Care Center Cambridge Dorchester If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Dec. 24, 1 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 □ M 2 🗙 F Director 213-14-7556 86 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at MD Dorchester Cambridge 1 XYes 2 No Director 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 'natural", or items 23a or 200 Meteor Ave. Apt. 101 21613 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No þ white 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) line worker unknown seafood es 1 and 2 should be filed vol Health and Mental Hygie fitem 27 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alexander B. Robbins Rubye Elizabeth Simmons 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JoAnn Rumbley daughter 5503 Mallard Lane, Cambridge, MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1 Burial 2 □ Cremation 3 □ Removal from State Sandy Island Cemetery: 3/18/08 Robbins, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P. A. 21. Signature of Funeral Service Licensee B 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) HSpiration day /Medical Due o (or as a consequence of Examine shagia 6 months Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner that initiated events resulting in death) Last burial-tra Due to (or as a consequence of) physician Physician/Medical the as attending IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Cardio My O DOCTA 1 ☐ Yes 2 ☐ Wo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy performed? Severe phusis 2 1 NO 25. Was case referred to medical examiner? director 26. Place of Death Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, this After or Attending To the Hospital or Attendi within 24 hours after death. To the Funeral Director; ≯

within 72 hours after

Maryland 21215-0036

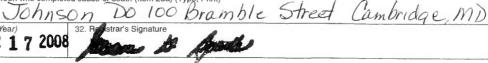
Baltimore,

completely State Registrar DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



29c. License number

H0059973

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	0	Telephone and the last	2	1

		•	1 - State Registrar	State of Ma	•	artment of Hea rtificate of De			ene	0 10127				
	Physici /Medic		Decedent's Name (First, Middle, L Anna N	ast) Mary	Shaffer			2. Date of Deat Mar 22,		3. Time of Death				
	Examin		4a. Facility Name (If not institution, git Allegany County N		е	4b. City, Town, or Lo Cumberlan			4c. County of Allegar					
	Funeral Director		5. Social Security Number 6. 217-18-4885	Sex 7. Age 1 M 2 F 84	(In yrs. last birthday) Yrs.		Under 24 Hrs. Hours Min.	8. Date of Birth Oct 22,	1923	Birthplace (State or Foreign Country)				
	Marylend f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Allegal	ny	10c. City, Town or Lo	perland				10d. Inside City Limits Y Yes 2 No				
	with the	Funeral Director	10e. Street and Number 101 Potomac Stre	et		10f. Zip Code 21 :	502	1	0g. Citizen of W	·				
036	within 72 hours after death with the Marylend ene. Intan "natural", or Itams 23a or 28e-f show ha Medical Examinar must be notilied at	þ	11. Marital Status 1 Never Married 2 Married X Widowed 4 Divorced	12. Was Decedent B Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of Hispa If Yes, specify Cuban, N	anic Origin? (Sp Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black	- American Indian, K. White, etc. White				
21215-0036	be filed within 72 horital Hygiene. Id other than "natura event, the Medical	Completed	15. Decedent's It (Specify only highest g	Education rade completed) College (1-4or 5	(Give	dent's Usual Occupatio kind of work done durin DO NOT use retired)	n ng most of work	ing	16b. Kind of Bus					
land 2	be filed stal Hygi od other event, I	To Be Co	17. Father's Name (First, Middle, Las Walter Stewart	it)	Scarrio	18		e (First, Middle, M	Maiden Surname					
Maryland	Ith ar 27 Is r treu	-	19a. Informant's Name/Relationship Lorraine Ort	_(Турв, Print) friend		ng Address <i>(Street and</i> Gyros Court	Number or Run	Bel Air	, City or Town, S	MD 21014				
Baltimore,	0 0		20a. Method of Disposition 1 X Burial 2 Cremation 3 4 Donation 5 Other (Special Control of Contro			osition (Name of matory or other place) Veterans Cem	!		20c. Location - 0 Flintstor	City or Town, State				
Balti	permit. Page Department. Importent: It any Injury o		21. Signature of Funeral Service Vice	1/11		2. Name and Address C Scarpelli F 108 Virgini	a Avenue	 Cumberla 	and, MD 2	1502				
	Physician physician and physician and physician and physician street physician and physician street physician and physician ph	Examiner	23a. Paryf. Enter the disease, of coshock, or heart failure. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, I any leading turnine distance. Enter Underlying Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	isease or condition assulting in death) a										
P.O. Box	The law requires that the death certificate be executed the hes been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown Part II. Other significant conditions	time of death 5	□Ectopic pregnancy □ Other (specify)	n Part I.	23e. Did tol	Mon	a of delivery th Day Year ibute to the cause of death?					
Vital Records,	The law require rate hes been sig page 2 should b	Completed t						24a. Was a autops perforr	n 24b. V	3 Probably 4 Unknown Vere autopsy findings available rior to completion of cause of eath? Yes 2 No				
of	Physicien: r this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Inpatie 28a. Date of Injur (Month, Day	y 28b. Time o	nt 3 DOA Other:	4 Nursing Ho	th (Check only on ome 5 Reside 28d. Describe ho	ence 6 Othe					
Division	r Attenter deat irector:	Certification;	2 Accident investigati 3 Suicide 6 Could not determine	be See Bless of law	ury - At home, farm, st.	M 1 ☐ Yes	s 2□No	28f. Location (Si City or Town		er or Rural Route Number,				
	To the Hospital of within 24 hours at To the Funerel D completely filled in	Medical C		Physician: To the best of aminer: On the basis of and manner sta	examination and/or in									
1	To the within 2 To the Comple	Me	29b. Signature and title of certifier). 1sa	very. L	29c. License n	umber 1486	2	9d. Date signed 3 - 2	(Month, Day, Year) 2 - 2008				
	Sta Begistr	ite	30. Name and address of person when BOBUSTI ANG BAF 31. Date filed (Month Park Year)	COMPleted cause of display to the Complete Cause of display to the Complete Cause of the Complete Cause of display to the Complete Cause of the Cause of the Complete Cause of the Ca	eath (Item 23a) (Type, M HOSE ar's Signature	Print) TON MED	BLDG	Cume	BRLANT), MD alsoa				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 11:45 A M 23 2008 March George S. Switzer /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Calvert Solomons Solomons Nursing Center 8. Date of Birth (Month, Day, Year) June 11, 1 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 547-09-8997 1915 California 92 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Port Republic MD Calvert 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20676 2870 Scientist Cliffs Road Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or iter 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify 3altimore, Maryland 21215-0036 Specify. white Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Smithsonian Institution Mineralogist 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Be Switzer Charlotte Elizabeth Albert James ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2870 Scientist Cliffs Road, Port Republic MD 20676 Switzer, spouse Sue Joan 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If Ite any injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 03-26-2008 Prince Frederick, MD St. John Vianney 4 □ Donation 5 □ Other (Specify) Rausch Funeral Home, P.A. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 4405 Broomes Island Rd. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cardio Vascular disease Physician Atherosclerotic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year jo in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by Dysphagio 1 ☐ Yes 2 ☐ No 3 ☐ Probably cate has been a Were autopsy findings available prior to completion of cause of 24a. Was an Cancen death? 1 ☐ Yes performed? (es 2 No 2 No Dementia Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one director, Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 □Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c, License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 50653 3-24-2008 GYAN . C. SURANA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5851 -Churchten Deale Road Peale 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

15

ORIGINAL

VOID

CERTIFICATE

2008 - 10129

SEE

CERTIFICATE #

2008-10824

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of Ma		partment of H ertificate of I			ene		
Physic /Med		1. Decedent's Name (First, Middle, Lass		en III			2. Date of Death Month March	9 20	3. Time of Death 0	
Exam		4a. Facility Name (If not institution, give		ital	Oakland	Location of Death		4c. County of	tt	
Funera Directo		5. Social Security Number 6. Se 220 32 4908 16	x 7. Age	e (In yrs. last birthda Yrs.	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb. 5	Year) 1936	9. Birthplace (State or Foreign Country) Loch Lynn MD	
the Maryland 28a-f ehow	rector	10a. State 10b. County MD Garret 10e. Street and Number	t	10c. City, Town or			10	g. Citizen of W	10d. Inside City Limits 1 ☐ Yes 2 🛣 No /hat Country?	
DESIGNMOTE, INSIGNICALIA-UUSO permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than "natural", or Items 23a or 28a-f ehow any injury or other treumatic event, Ira Madical Examinar must be notified at	Completed by Funeral Director	1116 Garrett Rd. 11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 ∑Yes 2 ☐ N If Yes, Give Year or Dates:	1957-59	1 ☐ Yes 2 ☒ No	ispanic Origin? (Span, Mexican, Puerto Specify: ation	Rican, etc.)	Specify.	a - American Indian, k, White, etc. . White siness/Industry	
a filed within 72 at Hygiene. I other than "na vent, the Madic		(Specify only highest grade Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)		i+)	ive kind of work done e. DO NOT use retired umber	during most of work		Plumbi		
aryland aryland should be fi and Mental H marked oth	To Be	Benjamin F. Shaf			ailing Address (Street	Mildred	V. Harv	ey		
DESIGNATION CE, INSTRUCT CLISTONS Dermit. Pages 1 and 2 should be filled within 72 hours all Department of Health and Mental Hygiene. Important: if Item 27 ie marked other than "natural", or any injury or other treumatic event, the Madical Exemple in the Company injury or other treumatic event, the Madical Exemple.		Barbara Shaffer 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		cemetery, c	6 Garrett sposition (Name of crematory or other place t Valley (^(e)	Date 2	Oc. Location -	City or Town, State t Valley MD	
permit. I Departm importal any inju		21. Signature of Funeral Service Licen	500 c/		22. Name and Addre	St. Oaklar		.550		
box 68760, death certificate be executed e attending physician and ed or use as the burial-transit	Ical Examiner	23a. Pant. Enter the disease, or come shock, or heart failure. List only of the shock, or conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as b. Due to (or as c.	10.	actory			51,	Approximate Interval Between Onset and Death 15 - 10 - 10 - 10 - 10 - 10 - 10 - 10 -	
death certified attending	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 Ectopic pregnancy 5 Other (specify)	y		23d. Dat Mo	te of delivery nth Day Year	
ecords, P.O. law requires that the as been signed by th	<u>م</u>	Part II. Other significant conditions of	ontributing to death b	ut not resulting in th	e underlying cause giv	ven in Part I.	23e. Did tob		nibute to the cause of death? 3 Probably 4 Unknown	
The The page	Completed							ned?	Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No	
Off Off Vital Iding Physician: 1 Ith. After this certification of the price of t	tlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1		e of 28c. Injury	ner: 4 ☐ Nursing Ho	h (Check only one ome 5 ☐ Reside 28d. Describe ho	nce 6 □Oth		
DIVISION Lal or Attending s after death. at Director: Afte	Certification:		3 Suicide 6 Could not be 28e. Place of Injury				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
DIVISION OF To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	edical	(Check only 2 Medical Examone)	ysician: To the best niner: On the basis o and manner st	of examination and/o	- 20c Licens	opinion, death occur	red at the time, da	ate and place,	anner as stated. and due to the cause(s) d (Month, Day, Year)	
To To Con	Σ	1 Rould	E-6	Lys	0	se number		-	16/08	
		30. Name and address of person who	5. Gre	death (fem 23a) (Ty	be, Print)	rial on	000	6/and	, 40 21550	
Regi	State strar		2008 32. Hegisti	and Signature	Anch s					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U U Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Lest) Month 3/12/2008 **Physician** 4:35 AM Sandra Ellen Starr /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street and number) Examiner Carroll Westminster Carroll Hospice Dove House If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex **Funeral** Months Days 1 □ M 2 🕱 F MD 3/28/1957 218-70-6060 Usual Residence of Decedent 50 Director 10d Inside City Limits 10c. City. Town or Location 10a State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f aho other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Sykesville Director Carroll MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number TISA 21784 6505 Shenandoah Dr. Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status 1 Never Married 27 Married 1 ☐ Yes 2 X No Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16h Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Turf Valley Resort Assistant Controller 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Lest) Be May Eva Evans Howard William Schuder ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6505 Shenandoah Dr., Sykesville, MD 21784 Bob Starr/Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Purial 2 ☐ Cremation 3 ☐ Removal from State 3/15/08 Sykesville, MD Lake View Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) Burrier-Cuefficituneral Home & Crematory, P.A. 21. Signature of Funeral Service Licensee 1212 W. Old Liberty Rd., Winfield, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Small Cell Lung Cancer Immediate Cause (Final disease or condition resulting in death) 7 months /Medical Examiner Physician/Medical Examine attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobecco use contribute to the ceuse of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 should Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Dother (Specify) HOSPICE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No 2 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 1 ✓ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edicai completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie D 29246

To the I within 2 To the F

The law requires that the death certificate be executed

or Attending Physician:

after death. Director: Aft

24 hours

has

Division of Vital Records, P.O. Box 68760,

the Manyland

permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Heatlh and Mental Hygiene. Important: If item 27 is merked other than "natural", or items 23a or :

Saltimore, Maryland 21215-0020

WJZ

30. Name and as ress of person who completed cause of death (Item 23a) (Type, Print) Natvarlal Rajpara, M.D. 224 Washington Hents Med. Ctn., Westminster, MD Hghts. Vi 32. Registrar's Signature Washington

Natvarlal Rajpara, M.D.

31. Date filed (Month, Day, Year) MAR 14 Registrar

Glown & Spark

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 4Pay 2008 March **Physician** Cheryl D. Spriggs 12:45Am /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Tate Chesapeake Hospice House Linthicum Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Aug 16 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** ^{Yea}r) 1960 Maryland 213-78-5851 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatlth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at Yes 2□No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 116 Dogwood Rd. 21403 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th 4yrs Administrator Law Firm 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Everett E. Spriggs Audrey A. Chew ျ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela T. Spriggs(Sister) 2140 Clearview Dr. Owings, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 3-12-08 Spriggs Cemetery Dunkirk, Md. 4 ☐ Donation 5 ☐ Other (Specify) Windows Brevers of EaciliSons Mortuary, P.A. 21. Signature of Funeral Service Licensee Lavry esa 1160483 821 West St. Annapolis, Md. 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Uron /Medical Due to (or as a consequence of)! Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed burial-transit Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical the IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? for 4☐Pregnant at time of death 9☐Unknown Month Day Year 5 Other (specify) ed by the a detached f 9 Unknown cate has been signed | page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No certificate has 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Hospina Hold 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature me an 31 Date filed (Mon Year) MAR 11 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 9 per fth 8878 4-4-08 yt.
State of Maryland Phepartment of Health and Mental Hygiene Certificate of Death Reg. No. 🛴 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death I I 2008 March 8:33 \mathbf{p}^{M} Richard William Tasker 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Garrett Garrett Co. Memorial Hospital 0akland | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Sept. 20) 9. Birthplace (State or Foreign Country) MD• 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 X M 2 □ F 1941 Vindex 220 40 1376 66 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Garrett Swanton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21561 3366 Walnut Bottom Rd. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1959 1 ☐ Never Married 2X Married 1 ☐ Yes 2 🖾 No Specify: White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Coal Miner Coa1 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Virginia Hanna Foster Tasker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3366 Walnut Bottom Rd. Peggy Tasker Swanton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 3-14,08 Mt. Zion, MD Mt. Zion Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility David A. Burdock 21 N 2nd. St. 0 k Funeral Oakland, Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ARTERIO SCUTROTIC CORONARY ARTERY DISEAS years Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE

Physician /Medical Examiner The law requires that the death certificate be executed

Physician

/Medical

Examiner

10a. State

MD

12

Director

Funeral

Completed by

Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Saltimore, Maryland 21215-0036

Examine burial-transit and aftending physician for use as the buria Medical been signed by the should be detached certificate has b irector, page 2 s funeral director

Division or Vital Records, P.O. Box 68760,

al or Attending Fath. neral Director: /

To the Hospital within 24 hours at To the Funeral D

Physician/l	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of o	al death 3 □Ectopic			23d. Date of delivery Month Day Year					
ģ	Part II. Other significant conditions of	contributing to death but not res	sulting in the underlying	g cause given in Part I.		ise contribute to the cause of death? ☐ No 3 ☐ Probably 4 ☐ U nknow					
Completed					24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No					
Be (25. Was case referred to medical examiner?	26. Place of Death (Check only one)									
0	1 Pres 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□	DOA Other: 4 Nursing	Home 5 ☐ Residence	6 □Other (Specify)					
	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injur	y occurred					
Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At h building, etc. (Special		ory, office	28f. Location (Street an City or Town, State	d Number or Rural Route Number,)					
ica O		nysician: To the best of my kniner: On the basis of examin				and manner as stated. I place, and due to the cause(s)					

State

(Check only one)

29b. Signature and title of certifie

Tue Dans

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

H26154

Acres Drive Oukland, MD 21550 Miller Do 69 Wolf 31. Date filed (Month, Day, Yea 32. Registrar's Signature

29c. License number

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. _ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 MARCH 7, **Physician** 11:55 M Charles William Turner, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ALLEGANY WMHS - MEMORIAL CAMPUS CUMBERLAND If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Sept. 16, 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Hours Days Yearl Months 1 M 2 □ F 1930 Maryland 213-24-6130 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2 No Director Lonaconing MD Garrett 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or 7 21539 TISA 106 Green Lantern Rd. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 'natural", or Items dical Examiner mi 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or iten any injury or other traumatic event, the Medical Examinar 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No þ Specify. 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Roads 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sarah Adele Garlitz Joshua Hammond Turner ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 106 Green Lantern Rd., Lonaconing, MD 21539 Ruth B. Turner/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Grantsville Cemetery March 8, 2008 Grantsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundial Service Licensee 22. Name and Address of Facility Newman Funeral Homes, P.A. ound P.O. Box 275, Grantsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 1 MONTH CONGESTIVE CARDIAC FAILURE /Medical Due to (or as a consequence of) Examiner 1 WEEK RENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed AORTIC VALVE REPLACEMENT 3 YEARS burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown

2 🗌 No

23e. Did tobacco use contribute to the cause of death?

3 ☐ Probably 4 XUnknown

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes ※☐ No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 1 Yes 2 No

27. Manner of Death

1 Natural 2 Accident 5 ☐ Pending investigation 6 □ Could not be 3 ☐ Suicide 4 Homicide

1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 🗌 Yes

autopsy performed Yes X□No

24a. Was an

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number D58655 29d, Date signed (Month, Day, Year) 2008

30. Name and address of person who completed cause of deaty (Item 23a) (Type, Print)

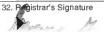
NAWAB, SABAHAT, M.D., 32 CORPORATE DRIVE, GRANTSVILLE, MD 21536

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

31. Date filed (Month, Day, Year)

12 MAR 2008



been signed be should be deta

page 2 s

director,

After

n 24 hours after death.

The Funeral Director: A pletely filled in by the funeral pletely filled in

within 24 hor To the Fune completely fi

To the Hospital or Attending Physician:

þ

Completed

Be

Certification: To

Medical

29a. Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State of Maryland / Departr Certifity	ment of Health and Me icate of Death	ental Hygien	2000 10100
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month D	3. Time of Death
	/Medic	al	Albert Talford 4a. Facility Name (If not institution, give street and number) 4b	c. City, Town, or Location of Death	Mar 8 200	08 2:45 p ^M Ic. County of Death
	Examin	ier	D 11 D1 34	Oakland		Garrett
	Funeral Director		5. Social Security Number 247-52-1321 6. Sex 1	Under 1 Year If Under 24 Hrs. 8 onths Days Hours Min.	B. Date of Birth (Month, Day, Yea 04-11-34	
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Locatic	on		10d. Inside City Limits
	Mary	tor	MD Garrett Oakland			1 ☐ Yes 2 ☐ No
	th the	lirec	10e. Street and Number 1	Of. Zip Code	10g. C	Citizen of What Country?
	ath wi	rai	1113 Mary Dr.	21550	U	SA
036	urs after dea al', or Iteme Exeminer m	by Funeral Director	13∑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	Decedent of Hispanic Origin? (Specis, specify Cuban, Mexican, Puerto Ri Yes 2 No Specify:	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mentall Hydiene. Important: If them 27 is marked other than "netural", or iteme 23e or 28e-f show eny injury or other traumatic event, the Madical Exeminer must be notified at once.	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 16a. Decedent' (Give kind life. DO No. 1) (Give kind life. DO No. 1) Disate	166.	Kind of Business/Industry	
Maryland 2	uld be fited Mental Hygi irked other itic event,	To Be Co	17. Father's Name (First, Middle, Last) Josh Talford	18. Mother's Name (in Estelle		an Sumame)
Man	12 sho h and I remma			ddress (Street and Number or Rural F 3 Mary Dr. Oakla		v or Town, State, Zip Code) 21550
lore, l	ages 1 and nt of Health : If Item 27		20a. Method of Disposition 1 □ Burial 2 ☑Cremation 3 □ Removal from State	on (Name of Dat	te 20c.	Location - City or Town, State
Baitimore,	permit. Pa Department Important eny Injury		21. Signature of Funeral Service Licensee 22. Na	ame and Address of Facility Dav		rdock Funeral Home 21550
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.		respiratory arrest,	Approximate Interval Between Onset and Death Application
	death certificate be executed to the certificate be estending physicien and the certificate as the burial-transit to the certificate the certificate to the certificate the ce	icai Examiner	Se wentially list conditions ff any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Uue to (or as a consequence of): c. Due to (or as a consequence of): d.			
O. Box 68	at the death certifica by the ettending ph stached for use as ti	Physician/Med		opic pregnancy her (specify)		23d. Date of delivery Month Day Year
cords, P	w requires that the been signed by th should be detache		Part II. Other significant conditions contributing to death but not resulting in the under	. /	coo use contribute to the cause of death? 2 No 3 Probably 4 Unknown	
Hec	The law ate has t page 2 s	Completed by	hejpertension		24a. Was an autopsy performed?	
VItal	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (
5	ng Physiter this	ation; To	27. Manner of Death 1 Seatural 5 Pending (Month, Day Year) 28b. Time of Injury (Month, Day Year)		e 5 Residence	6 □Other (Specify) jury occurred
		Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)	f. Location (Street and City or Town, Sta	and Number or Rural Route Number, ate)	
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edicai	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, death occ on the basis of examination and/or investigation and manner stated.	igation, in my opinion, death occurred	at the time, date a	and place, and due to the cause(s)
	t with	Σ	29b. Signature and title of certifier Margaret area (29c. License number D 26650		Date signed (Month, Day, Year) 3 - 8 - 2008
	Sta Registr		30. Name and address of person who completed cause of death (Item 23a) (Type, Print March 13079 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature MAR 1 1 2008	wett highway	ake	1-8-2008 land, MD 21550

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month Decedent's Name (First, Middle, Last) **Physician** 2008 Genevieve Twardowski /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GLEN HSURNIE ANNE BALTIMORE WASHINGTON MEDICAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4/1/1925 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 □ M 2 🖺 F 210-16-3391 82 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Martal Hygbiens. In John Hems 23a or 28a-f show Important: If item 7 is marked other than "natural" or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at Anne Arundel Severn MD 1 □Yes 217 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21144 1235 Reece RD. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2**X**No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 No by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Own Home Homemaker Baltimore, Maryland 21 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frances Arasim Anthony Mikulski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 5649 Gresham Circle Parkville, MO 64152 Joseph Twardowski 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Cemetery | 3/10/2008 Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licenses about 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical **Examiner** ONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed physician ar s the burial-t Due to (or as a consequence of): Box 68760. Physician/Medical attending phase as the IF FFMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month 5 Other (specify) led by the a Division or Vital Records, P.O. 9 Hllnknown signed by d Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed page ; 2 No 1☐ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 1 Inpatient this 2 ER/Outpatient 3 DOA 27. Manner of Death 1 ☑ Natural funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director; A 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

MAR 1 1 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32 Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	Olato of	mar y lari	Ce	ertificate of	Death	R	eg. No. 2 U U	8 10137
i	Physicia	an	1. Decedent's Name (First, Middle	Decedent's Name (First, Middle, Last) 2. L							3. Time of Death
	/Medic	al	JOSEPH FRANCIS 4a. Facility Name (If not institution		4b. City. Town, o	or Location of Deal	MARCH	16, 2008 4c. County of E			
	Examin	er	CHESTER RIVER					TERTOWN		KEN	T
	Funeral Director		5. Social Security Number 022-16-0272		7. Age (In yrs. I	as <i>t birthday</i> Yrs.	Months Days	If Under 24 Hrs Hours Min		, Year)	Birthplace (State or Foreign Country) MA
	land bw at		Usual Residence of Decedent 10a. State 10b. County	,	10c. City	, Town or L	ocation		,,,,		10d. Inside City Limits
	a-f sh	ctor	MD KENT		СНЕ	STERT	OWN				1 X]Yes 2 □ No
	death with the Maryland Hms 23a or 28a-f show r must be notified at	al Director	10e. Street and Number 477 HERON POL	NT			10f. Zip Code 2162	20	1	10g. Citizen of Wha	t Country?
2-nn3e	be filed within 72 hours after death with the Marylar that Hyglene. ed other than "natural", or Items 23a or 28a-f show other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorced	Armed Formation 1 X Yes If Yes, Give	2 □ No		. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2🌠 No	an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		American Indian, White, etc. /HITE
Ş	72 ho 'natur dical	eted	15. Deceder (Specify only highe	nt's Education est grade completed)		(Giv	edent's Usual Occu re kind of work done	durina most of wo	orking	16b. Kind of Busin	ess/Industry
7	filed within Hygiene. ther than '	Completed	Elementary/Secondary (0-12)	College (1-			DO NOT use retire F OF THE	•		US GOVER	NMENT
ק ס	e filed val Hygie other i	Be C	17. Father's Name (First, Middle					1	me (First, Middle,	Maiden Surname)	
yland	should be and Mental marked o	To E	MICHAEL J. V.	AUGHAN					A MARIE		
Mar	12 sho		19a. Informant's Name/Relation				ling Address (Stree				nte, Zip Code)
ď	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic		BARBARA VAUGH 20a. Method of Disposition	AN/WIFE	20b. P	lace of Disp	HERON POI		ERTOWN , Date	MD 21620 20c. Location - Cit	y or Town, State
ē	Pages ent of nt; If II		1 ☐ Burial 2 ♣ Cremation 4 ☐ Donation 5 ☐ Other (State		ematory or other pla KE CREMAT	i i	9/2008	STEVENSVI	LLE. MD
Baltimor	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		21. Signature of Funeral Service)	F	22. Name and Addr ELLOWS B 30 SPEER	ess of Facility	N & NEWN	AM FUNERA	L HOME
b			23a, Part1. Enter the disease, of shock, or heart failure. Lis	or complications that cast only one cause on ea	aused the death						Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. ASP	IRAH or as a consequ		OF GAS	TRIC CO	ntents	5	Onset and Death 25 minule.
	Examiner		Sequentially list conditions, if any, leading to immediate	b. ESO	PHAG	EAL	- DYSFL	NCTION)		Commths >10 yr.
	ted nsit	niner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		or as a consequ LAMOU	NECK	>1045				
,	rtificate be executed ng physician and as the burial-transit	Examin	that initiated events resulting in death) Last	c Due to (or as a consequ	uence of):	LL GITT				3
8/6U	ate be nysicia he buı	Medical		d							
Box 6	death certif e attending ed for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No		irth 2□Feta ant at time of d	death 3	B □Ectopic pregnand □ Other (specify)	су		23d. Date o	
л О	requires that the neen signed by the		9 □ Unknown Part II. Other significant condit	tions contributing to de	eath but not resu	ulting in the	underlying cause gi	iven in Part I.	23e. Did to	obacco use contribu	ute to the cause of death?
ds,	uires l 1 signe	d by							1 1	res 2 No 3	Probably 4 ☐Unknown
Hecords,	sician: The law rec certificate has beer irector, page 2 shou	Completed	24a. Was an autopsy performed?								re autopsy findings available or to completion of cause of ath? Yes 20 No
VIta	lan:]	BeC	25. Was case referred to medic examiner?	al					1□ Yes eath <i>Check onl</i> o		
or <	Physiclan: rr this certificaral director,	은	1 ☐ Yes 250 No	-	·	ER/Outpati	ent oll box			dence 6 DOther	
on o	ding F h. After funera	tion:	27. Manner of Death 1 Natural 5 □ Pend inves	ing 28a. Date of (Mont) (Mont)	th, Day Year)	Injury	/ Wo	uryat ork?]Yes 2∐No	280. Describe i	low injury occurred	
DIVISION	l or Attence after death Director: in by the	Certification:	2 Accident investigation 3 Suicide 4 Homicide determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Investigation) 28f. Location (Street and Number or Rural Route Investigation)								
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical Co		ing Physician: To the al Examiner: On the ba and manr							
	To the Hos within 24 h To the Fun completely	Me	29b. Signature and title of certifi					nse number		29d. Date signed (
}	10+		> Strut	Whe	mo		D	00415	87	3/19	108
	ms		30. Name and address of perso	n who completed caus	e of death (Item	n 23a) (Typ	e, Print) DEEC RC	Chas	Lector 10	MD -	71670
	Sta	at <u>e</u>	31. Date filed (Month, Day, Yea	r) 32. R	egistrar' jigna		MKI KCI	· CNO	7000	1110	0,450
	Regist		لفة	ND 1 a DANS	Mann		M. Kanal				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 4 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Carol Villiotti 2008 8:15 p 11, March /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 11526 Soward Drive Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Days Hours Months 1 □ M 2 T F 579-24-9267 Yrs 82 1925 Dec. 29, Washington, DC Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 ☐ Yes 2X No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11526 Soward Drive 20902 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify Specify: White þ ¾☐Widowed 4☐Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Winston L. Jones Florence Boswell ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Linda A. Vincent/Daughter 3511 Harrell Street, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State March 17 Gate of Heaven Cemetery 4 □ Donation 5 □ Other (Specify) 2008 Silver Spring, Maryland 22 Name and Address of Facility. Francis J. Collins Funeral Home Inc. 500 University Blvd, W,. Silver Spri 21. Signature of Funeral Service Licensee Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Adenocarcinoma of Unknown Primary Months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician ar s the burial-t Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA P this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 🔼 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 24 and manner stated. within To the 29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760.

State Registrar

29b. Signature and little

30. Name and add

Jeanne/

Asher, MD

3720 Farragut Avenue, Kensington, MD 20895 32. Figistrar's Signature

ss of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

D34032

March 13, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2008 Year **Physician** 4:20 p M Fox Villella March 12, Lorraine /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Montgomery General Hospital Olney 8. Date of Birth (Month, Day, Yes Sept. 18, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year) 1925 **Funeral** Days Months Hours 1 ☐ M 2 🔀 F Massachusetts Sept. Yrs. 579-20-6115 82 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be matter to once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☐ No Montgomery Silver Spring Maryland Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20906 15115 Interlachen Drive, #316 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XI No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛭 No Specify. SpecWhite \$ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Copy Writer Direct Mail Advertising 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian McPherson Charles Fox P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2824 Glenwood Springs Drive, Glenwood, MD 21738 Lynn Villella Gray/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State March Gate of Heaven Cemetery 4 Donation 5 Dother (Specify) 2008 Silver Spring, Maryland 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licenses 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Em., the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acute days disease or condition resulting in death) tubular MECHOSIS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Linter University Cause (Disease or injury Due to (or as a consequence of) Examine g physician and as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 No Day 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an certificate has b irector, page 2 s autopsy perforn 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and/manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Lysicia 13,2008 DU055694 March 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALOK 20832 MID 108 Olacy, MATHUR

Registra DHMH 17 Rev 1/2001

State

31. Date filed (Month Pay

32. Resistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 3/7/2008 7:00am Marie Larrimore Vallandingham 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Anne Arundel Medical Center Annapois If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav) 5. Social Security Number 6. Sex Days Hours Min 1 M 2 T F 12/14/1935 MD 219-26-8432 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Anne Arundel Edgewater 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21037 USA 3956 Honevsuckle Dr. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 X No Specify 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dept of Housing State of Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lottie Sherbert Edward Larrimore SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) West River, MD 20778 4310 Charles Gift Ct. Deborah Tolliver Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Mem Gardens 3/12/2008 Annapolis, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Hardesty Funeral Home, P.A. Annapolis, MD 21401 12 Ridgely Ave. al 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 4m6uia (or as a consequence of): Due t Sequentially list conditions, if any, leading to immediate cause. Enter Underl, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknow 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical **Examiner**

Physician

/Medical

Examiner

MD

Director

Funeral

þ

Completed

Be

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

requires that the death certificate be executed

burial-trar JSe for ed by the a detached f signed to , page 2 s certificate has

Examiner Physician/Medical this

Completed by

Be

25. Was case referred to medical examiner?

1 🗌 Yes

27. Manner of Death 1 ☐ Natural 2 ☐ Accident

3 ☐ Suicide

29a, Certifier

4 Homicide

2

29b. Signature and title of certifier

Division or Vital Records, P.O. Box 68760, funeral director, After Hospital or Attending thin 24 hours after death.

the Funeral Director: Aft
ompletely filled in by the fur 0

State

Registrar

Medical Certification: To

31. Date filed (Month, Day, MAR 1 1 2008

-

5 Pending investigation

6 ☐ Could not be

Hospital:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Inpatient

28a. Date of Injury (Month, Day

and manner stated.

PISC up gistrar's Signature

2 ☐ ER/Outpatient

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

3□ DOA

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

1724864

24a. Was an

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death Check onl one

autopsy performed? Yes 2 No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Physician /Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 28a or 28a-f show any lury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burtal-transit

Division or Vital Records, P.O. Box 68760,

4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Chevy Chase S. Social Security Number 059-40-9034 1 M 2 F 57 Yrs. Chevy Chase Chevy Chase Montgomery S. Social Security Number 059-40-9034 1 M 2 F 57 Yrs. Months Days Hours Min. Md 1. 23, Year) 950 Work Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Chevy Chase Montgomery 10d. Inside City Lim 1 Maryland Montgomery 1 Off. Zip Code 3414 Bradley Lane 1 Marital Status 1 Martial Status 1 Martia		1 - For State Registrar		Ce	rtificat	e of Deat	th		eg. No.Z U	UB	101	l.		
As Land La	an	Decedent's Name (First, Middle, Last)	Josephine	WOLL)8 ^{ear}				
Security Number Security N	al er	4a. Facility Name (If not institution, give str	· · · · · · · · · · · · · · · · · · ·		4b. City,	Town, or Location	on of Death							
Superant Content	Sys	3414 Bradley Lane				evy Cha	se							
Top. State Top. Country Top. City: Town or Location Top. City: Town or Location Top. City: State Top. Country To		059-40-9034					rs Min.	Mar. 23	, ^{Yea} (1)950	Cou	intry)	Forei		
10.0. Street and Number 34.14 Brad ley Lane 10.7 20 Code 20.815 100, Citizen or What Country? 20.11 ted States 11. Maritat Status 12. Was Dependent Ever in U.S. 13. Was Dependent Control of Code 14. Pages A. American Indian. 15. Maritat Status 14. Pages A. American Indian. 15. Maritat Status 15.			10	c. City, Town or Lo	ocation	· · ·					10d. Inside City	/ Limi		
Specify with the specific process Specify	20	Maryland Montgome	ry	Chevy	Chas	e					1 ☐ Yes	2 \		
Specify with the specific process Specify	a Cie				10f. Zip			1						
Specify with the specific process Specify	nuel		Armed Forces?	r in U.S. 13.	Was Dece If Yes, spe	dent of Hispanic cify Cuban, Mex	Origin? (Spe ican, Puerto	ecify Yes or No- Rican, etc.)						
19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, Righ	5	3 Widowed 4 □ Divorced	Year or Dates:			Λ	cify:							
19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, Righ		15. Decedent's Educa (Specify only highest grade of	completed)	16a. Dece	dent's Usu kind of wo	al Occupation ork done during ri se retired)	nost of worki	ing	16b. Kind of B	lusiness/Ir	ndustry			
19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, Righ		Elementary/Secondary (0-12)	College (1-4or 5+) 5+		_				Howard	Univ	ersity			
19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, France) 19a. Mailing Address (Street and Number or, Right Fourth, Righ	Š			_		18. Mo				me)				
19th Informante Name/Relationship (Type. Print) 19th Nation Astronomy (State) (19th Name of Cartifolia) (19th Name of			Morton Wol	1			Alic	e Furma	n					
Mt. Lebanon Cemetery Adelphi, MD		19a. Informant's Name/Relationship (Type Diana Zurer, Siste	e. Print) Y	19b. Maili 4701	ng Address	s (Street and Nu ard Ave	mber or Rura ••• #83	B6, Chev	; City or Town y Chase	, State, Zi e , MD	^c 20815	5		
Adelphi, MD 21. Signification of Florent Service Lesson Cemetery 15. Per the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 25. Line The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 25. Line There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 26. Place of Death (Inc. of the cause) 27. Line Bath 27. Line Bath 28. Line Bath 29. Li			Chata	20b. Place of Disponentery, cre	osition (Na	me of other place)	03/14	Pate 1708	20c. Location	- City or T	own, State			
23a. Part I. Effect the disease, or complications that caused the death. Do to enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate cause (Final resulting in death) resulting in death) B			movai from State	Mt. Leba	non_0	emetery		,, 55	Adelpl	hi, M	ID			
23		21. Signature of Funeral Service Licenses		1.00		•				DC	20012			
IF FEMALE Due to (or as a consequence of):		23a. Part1. Enter the disease, or complica	ations that caused the								Approximate	yoon		
Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate Cause (Disease or injury that imitated events resulting in death) Last Cause (Disease or injury that imitated events resulting in death) Last Cause (Disease or injury that imitated events resulting in death) Last Due to (or as a consequence of): C.		Immediate Cause (Final		1	Onset and D	eath								
Due to (or as a consequence of): Due to (or as a consequence of (or all or		resulting in death)										_		
Due to (or as a consequence of): Due to (or as a consequence of to (or all or all or all on the cause of death or all		b												
Due to (or as a consequence of): Due to (or as a consequence of to (or all or all or all on the cause of death or all	5	sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):												
See the control of the cause of death of t	Z	Cause (Disease or injury that initiated events c.	Due to /or on a	nacauana of).										
FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Ves 2 No 9 Unknown 1 Unknown 1 Ves 2 No 9 Unknown 23c. If yes, outcome pf pregnancy 1 Unknown 1 Ves 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Ves 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Ves 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Ves 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Ves 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Ves 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Ves 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Ves 2 No			Due to (or as a co	onsequence or).										
FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Ves 2 No 9 Unknown 1 Unknown 1 Ves 2 No 9 Unknown 23c. If yes, outcome pf pregnancy 1 Unknown 1 Ves 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Ves 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Ves 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Ves 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Ves 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Ves 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Ves 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Ves 2 No	2	d.												
24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28b		23b. Was decedent pregnant in the past 12 months?	23b. Was decedent pregnant in the past 12 months?									-		
24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28b	33	9 Unknown	9□Unknown					_						
25. Was case referred to medical examiner? 1 Yes 2 No Hospital: I Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 4 Homi	7	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.												
25. Was case referred to medical examiner? 1 Yes 2 No Hospital: I Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 4 Homi									n 24b.	Were aut	opsy findings a	ıvaila		
25. Was case referred to medical examiner? 1 Yes 2 No Hospital: I Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 4 Homi				-				perfor	med?	death?		use		
1 Yes 2 No		25. Was case referred to medical				26. P	lace of Death			7				
27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Underwined 28d. Describe how injury occurred		spital: 1 ☐ Inpatient	2 ER/Outpatie	nt 3 D	OA Other: 4	Nursing Ho	me 5/ Reside	ence 6 □Ot	her (Spec	ify)				
D 0033293 March 12, 2008		27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury at Work? 28d. Describe how injury occurre												
D 0033293 March 12, 2008		3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office 28f. Location (Street and Number of									ral Route Numb	ber,		
D 0033293 March 12, 2008		(Check only 2 Medical Examine	er: On the basis of ex	amination and/or in	th occurred	at the time, date n, in my opinion,	e and place, death occur	and due to the o	ause(s) and material	nanner as , and due	stated. to the cause(s))		
20 Now and address of second lated to the Color (to Do) (Type Dript)		29b. Signature and title of certifier	1/1		29	c. License numb	er	2	9d. Date sign	ed (Month	, Day, Year)			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick P. Smith, M.D., 5454 Wisconsin Ave., Suite 1300, Chevy Chase, MD 20815	MIC	1				D 00332	293		March	12,	2008			
	ME													

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** М CLEMENT 03 GAIL WILMOTH 17 08 0455 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** WMHS BRADDOCK CAMPUS CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Mar 16 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1952 56 218-60-0363 Director Virginia West Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at WV Mineral Keyser 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 441 Ward Ave 26726 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: NO Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: White þ 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Vault Setter Shank Vault Company Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be fi Department of Health and Mental In Important: If Item 27 is marked ott any Injury or other traumatic even once. Be Pages 1 and 2 should be nent of Health and Mental Edward Twyman Carol Wilmoth 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 57 Erin St, Piedmont, WV Carol Twyman/Mother 26750 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Keyser, WV Potomac Mem Gardens 3/21/08 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Boal Funeral Home, 111 Church St, Westernport, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to r as a consequence of): **Physician** UNKNOWN /Medical **Examiner** END SHAGE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed SMOKING and burjal-trai Due to (or as a consequence of): Box 68760. physician s the buria Physician/Medical attending phase as the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the a 9 I Inknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? certificate has 1□ Yes 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA 1 ☐ Yes 2 🔀 No 1 X Inpatient 2 ER/Outpatient Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier

Hospital or Attending n 24 hours after death.

The Funeral Director: A pletely filled in by the funeral completely within 2 To the

> State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifièr

(Check only one)

MAR 2008 32. Registrar's Signature

AIYER

and manner stated.

RAVI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Drive, Cumberlan

21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 12 03 80 ANNABELL WILKES 0440 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS BRADDOCK CAMPUS CUMBERLAND ALLEGANY 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Oct. 5, 1 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Months 1 ☐ M 2 🕱 F Days Hours 88 219-03-9777 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show iny or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD. Allegany Westernport 1 ☐ Yes 2 No Director 10f. Zip Code 21562 10e. Street and Number 10g. Citizen of What Country? PO Box 143 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☑ No If Yes, Give Year or Dates; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department Store Clerk unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Boslev Elenor Snyder ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau once. Beverly Grove/ niece 216 Poplar St., Westernport, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 03/12/ 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory Cumberland Maryland 2008 22. Name and Address of Facility Boal Funeral Home 21. Signature of Funeral Service Licensee 111 Church St., Westernport, Maryland 21562 23a. Part1. Enter the diseas, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Henry /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner use as the burial-trait Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☒ No Month 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Obstructive 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an cate has t page 2 s autopsy performed Bilaten certificate To the Hospital or Attending Physician: To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of eath 28a. Date of Injury 28h. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) → ANatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year)

State Registrar DHMH 17 Rev 1/2001 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Jesus

MAR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IAN

3

Broadwa

32. Régistrar's Signature

29c. License number

21244

12/2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Marylar	nd / Dep	artment of	Health	and Men	tal Hyg	giene	0.0	10111
			1 - State Registrar		Ce	rtificate of	Deati			Reg. No.	U B	10144
П	Physici	an	1. Decedent's Name (First, Middle,			11/0/1		N	ate of Dea	Day	Year	3. Time of Death
	/Medic	al	Jacque ne			4b. City, Town,	or Location		March	4c. County	JOOF Of Death	10:10 K M
	Examin	er	Tohns Huple.	1 Aoso tel		RIL	more.	Cita		10. 000,		
	Funeral	1	7 7	. Sex 7. Age (In yrs.	last birthday)	If Under 1 Yea Months Days	r II Unde	er 24 Hrs. 8. C	ate of Birth Month, Day	h y, Year)	9. Birthpl Count	ace (State or Foreign
	Director	,	569-64-4253	1□ M 2XF 64	Yrs.	Nona Suy		00	ct. 2	6, 1943	Ala	bama
	land ow	}	Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Li	ocation					10	d. Inside City Limits
	Many n-f sh	tor	Maryland Prince	George's Boy	wie							1X Yes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code			1	10g. Citizen of \	What Coun	try?
	deeth with the Maryland ims 23s or 28a-f show r rust be notified at	erai	3000 New Oak Lar	12. Was Decedent Ever in U	19 12	20716	Hispanic (Origin? (Specify		USA	e - Americ	an Indian.
	fter de	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🕅 No	1	Was Decedent of			n, etc.)		ck, White, e	
ğ	ours a	þ	3	If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 N	o Specii	fy:		Specify	Blac.	
215-0036	within 72 hours after ene. then "natural", or ite he Medical Examine	Completed	15. Decedent's (Specify only highest		(Give	dent's Usual Occ kind of work don DO NOT use retii	e during m	ost of working		16b. Kind of B	usiness/Ind	ustry
12	within iene.	omo	Elementary/Secondary (0-12)	College (1-4or 5+) 4+		stered N				Health	Care	
2	be filed within 72 hours after deeth with the Marylan Idathytyleine. Idathytyleine in atural; or itema 23s or 28s-1 show svent, the Madical Examiner must be notified at	BeC	17. Father's Name (First, Middle, La					ther's Name (Fir.	st, Middle,	Maiden Suman	ne)	
<u> a</u>	2 should be and Mental Is marked o aumatic sve	To	Eddie Means					garet Ha				
Maryland	TENE		19a. Informant's Name/Relationship Michael Walton/			ng Address (Stree New Oak					State, Zip	Code)
	s 1 and f Health Itsm 27 other to		20a. Method of Disposition	20b. I	Place of Dispe	osition (Name of		Date	TID Z	20c. Location -	City or To	wn, State
Ê	m O		1 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	☐Removal from State cify) Met	Lakemo	matory or other p ont Gardens	1000)	3/17/20	800	Davids	onvil	le, MD
Baltimore,	permit. Page Department Important: If sny Injury or once.		21. Signature of Funeral Service Lic		2	2. Name and Add		Robert Robert	E. :	Evans F	unera	
	207 29		Willer	Dure		16000 An					0715	Approximate
			23a. Part1. Enter the disease, or or shock, or heart failure. List or Immediate Cause (Final	ity one cause on each line.	th. Do not en	ter the mode of d	ying, such	as cardiac or res	piratory at	rest,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a consec	L dema	and Her	with	K				Loya .
	Examiner		Sequentially list conditions b. Cardiac Demand Is chemise									Flore
	be sit	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	sequence of):						V8/2000	
	be executed sicien and burial-transit	Examiner	Cause (Diseese or injury that initiated events resulting in death) Last	c						1	,	10 1000
/60	2 % 0	cai		a Progressian	and	Treetmen	t of	Aute	4440	gross Le	akenin	4 days
68	death certificat e ettending phy id for use as thi	Med	IF FEMALE:	0					0 (1	,
gox	ettend for us	Physician/Med	23b. Was decedent pregnant in the past 12 menths?	23c. If yes, outcome of pregn 1 Live birth 2 Feta 4 Pregnant at time of c	aldeath 3[☐Ectopic pregnar ☐ Other (specify)					ite ol delive onth	ry Day Year
o.	0 0	hysi	1 ☐ Yes 2 ☑No 9 ☐ Unknown	9□ Unknown								
ა ე	The law requires that the de ste has been signed by the page 2 should be detached	by P	Part II. Other significant condition	s contributing to death but not res	sulting in the u	inderlying cause o	given in Pai	rt I.		obacco use cont res 2 \(\subseteq \text{No} \)		e cause of death?
oro o	requir	eted				· · · · · <u>-</u>						abiy 4 □Unknown
Records,	e las has	Completed								rmed?/	death?	osy findings available inpletion of cause of
Vital		Be Co	25. Was case referred to medical				26. Pla	ace of Death (Ch			1 🗌 Yes	2 No
	Physician: this certific al director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2] ER/Outpatie	nt 3 DOA	Other: 4 🗆	Nursing Home	5 🗆 Resid	dence 6 Oth	ner (Specify	')
Division of	fter		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	W	jury at /ork? □ Yes 2		Describe f	now injury occur	red	
<u> </u>	vttendi deeth. ctor: A y the fu	licat	2 Accident investigal 3 Suicide 6 Could no	t be 299 Blace of Initial At h	nome, larm, st			28f. (Street and Numb	ber or Rura	l Route Number,
2	al or A s efter al Dire	Certification:	4 Homicide	building, etc. (Speci	ify)			1	City or Tov	vn, State)		
	To the Hospital or At within 24 hours effer of To the Funeral Direct completely filled in by		(Check only 2 Medical Ex	Physician: To the best of my known caminer: On the basis of examine	owledge, dea ation and/or in	th occurred at the ovestigation, in my	time, date opinion, d	and place, and dleath occurred a	due to the t the time,	cause(s) and made,	anner as st and due to	ated. the cause(s)
	To the within 2 To the compiet	Medicai	one) 29b. Signature and title of certifier	and manner stated.		29c. Lice	nse numbe	er		29d. Date signe	ed (Month,	Day, Year)
	rstō (1	· Com	- Medical D	octor	R	cs - C	000		March,	09	7008
١	14 CON	الر	30. Name and address of person w	no completed cause of death (Iter	m 23a) (Type							21227
	Sta	te.	Eli Bortz Joh 31. Date liled (Month, Day, Year)	132 Registrar's Sign	ature OC	NIVOTIL	1001+	e net	00011	mere inter	June	, , ,
	Registr		MAR 132	008 Jenn 1	4 6	andes.						

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State o	f Maryla	and / Depa	artmen rtificat			ind M	, ,	iene	008	10145
8	Physici	an	1. Decedent's Name (First	,	,	_						2. Date of Dear	Day	Year	3. Time of Death
•	/Medio	_	Alton Eu 4a. Facility Name (If not in Mallard B	stitution, giv	Wingate re street and number re Cente	mber)			Town, or	Location o	f Death	March		2008 ounty of Death Dorches	9:05 p ^M
	Funeral Director	7.45	5. Social Security Number 218–20–951	5	Sex 1⊠M 2∏F	7. Age (<i>In y</i> . 7 8	rs. last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day)	, Year)	Cour	olace (State or Foreign otry) yland
١	Aaryland f show ed at	or		county County	ester	10c.	City, Town or Lo		'ambr	idge				1	0d. Inside City Limits M∑Yes 2 ☐ No
L	with the I	al Director	10e. Street and Number 520 Gleni	ourn <i>P</i>	Avenue			10f. Zip		613		1	0g. Citize	n of What Cour USA	ntry?
)3e	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 (∑Never Married 2) 3 □ Widowed 4 □ Di		12. Was Dece Armed Fo 1 X Yes If Yes, Gi Year or D	orces? 2		Was Deced If Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto f	cify Yes or No- Rican, etc.)		. Race - Americ Black, White, pecify: Whi	etc.
Baltimore, Maryland 21215-0036	d within 72 ho giene. r than "natur the Medical I	Completed	15. Do (Specify only Elementary/Secondary (ducation ade completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usua kind of wo DO NOT us mach	rk done a se retired,	luring most)	of workin	ng		of Business/Inc chine s	•
yland 2	12 should be filed w n and Mental Hygie is marked other th raumatic event, th	To Be C	17. Father's Name (First, I Mitchell	Grant	Wingat	te				Lei	ila I	(First, Middle, I	hnso	n	
Mar	alth and 2 shugath and 27 is m		19a. Informant's Name/Re Marilyn R			p.r.						I Route Numbel		⁻ own, State, Zip 673	Code)
more	permit. Pages 1 and 2 Department of Health s Important: If item 27 li any injury or other tra once.		20a. Method of Disposition 1X Burial 2 □ Cren 4 □ Donation 5 □ C	nation 3		State	o. Place of Dispo cemetery, cree	matory or o	ther place	· _ :	3/15			ition - City or To ridge,	
Baltii	permit. Pag Department Important: If any injury o		21. Signatur of Funeral S		nsee		22	2. Name an	d Addres	s of Facilit	y Tho	mas Fur bridge,		Home P 21613	.A.
,760,	Physician /Medical Examiner thysician and physician and physician ithe priviler-fransit	ical Ex	23a. Part1 VEnter the dise shock, or heart failur Immediate Cause (Final disease or condition resulting in death) Se uentially list conditions if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	(a. Reconstruction Due to Due to c.	aused the or auch line. Chyrli (or as a cons dyor (or as a cons (or as a cons	equence of):	eme	e or aying	Pali	u Well	r respiratory arr	est,		Approximate Interval Between Onset and Death
Division or Vital Records, P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregn in the past 12 month 1 ☐ Yes 2 ☐ No 9 ☐ Unknown			oirth 2□F nant at time o	etal death 3	∃Ectopic pr ∃Other (sp					23	d. Date of delive	ery Day Year
rds, P	w requires that been signed b should be deta	ed by Pt	Part II. Other significant o	conditions	contributing to d	eath but not r	resulting in the u	nderlying c	ause give	en in Part I.		23e. Did to		/	he cause of death? pably 4 □Unknown
II Reco	sician: The law re s certificate has bee irector, page 2 sho	Completed										24a. Was a autops perfor	sv l	prior to co death?	ppsy findings available mpletion of cause of
· Vita	/sician: s certific director,	o Be	25. Was case referred to examiner? 1 ☐ Yes 2 ☑ No	nedical	Hospital: 1 🗆	Inpatient 2	☐ ER/Outpatier	nt 3□DC)A Othe			(Check only on ne 5 ☐ Resid		Other (Specia	f _V)
sion or	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific: completely filled in by the funeral director.	H	27. Manne Death 1	Pending investigation	28a. Date (Mon		28b. Time o		8c. Injury Work		2	28d. Describe h			71
Divis	ital or Att urs after de ral Directe lled in by t	Certification:	4 ☐ Homicide	Could not b determined	build	ing, etc. (Spe						City or Tow	n, State)		al Route Number,
	he Hosp in 24 hou he Fune pletely fil	Medical			miner: On the b		knowledge, deat ination and/or in								
	To ti To ti	Ž	29b. Signature and title of	certifier	duy r	10		290		number 479	i 24			signed (Month,	Day, Year)
	4+1		30. Name and address of	person who		se of death (I	tem 23a) (Type,	Print)							
	Sta Registr		31. Date filed (Month, I	AR"1	3 20082	Regionar's Sig	gnature	Son	K)			MI			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008	-		Application of the last	1	1
------	---	--	-------------------------	---	---

silly Lee vve		1- For State Control of Pleath and Wentan 1	-	eg. No.	UU	0 1014
Physici		Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Dea Month	th	ear	3. Time of Death
"≎al Exami	ner	Jeremy Lee Werner	March 18,	2008		1107 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 1701 Russell Street, Room 403 Baltimore	h	4c. County	of Death	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr	s. 8. Date of Bir	th (MM/DD/YYY		place (State or Foreign
Director		374-94-3105 1XM 2F 29 Yrs. Months Days Hours Min	n. Novem	ber9,1	978	^{ntry)} Michigan
any		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
A .	-	NorthCarolina Catawba Conover			İ	1 X Yes 2 No
Aaryla 28a-f 1 at o	Director	10e. Street and Number 10f. Zip Code	1	0g. Citizen of W	/hat Count	ry?
h the l 3a or otifie	ä	2300 Angle Drive 28613		U.S.A.		
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at once	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Single Fig. 1) If Yes, specify Cuban, Mexican, Puerton Company (Single Fig. 1) If Yes,			ce - America ite, etc.	an Indian, Black,
er dea		1 Yes XX No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes XX No specify:		Specify	Whi	te
urs aft tural	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of	work done	16b. Kind of E		
72 hor n "na al Exi	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	etired)	Ontic	. E:1	er Cable
215-0036 be filed within 7 ntal Hygiene. rked other than rnt, the Me lisa	ш	1 Cable Assembler				Der Cabre
21215-0036 uld be filed within 73 Mental Hygiene. marked other than c event, the Medical			ne (First, Middle,	Maiden Surnam	e)	
Z1Z Z1Z Duld be 1 Mental marke	o Be	Bruce A. Werner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or		mber City or To	wn State	Zin Code)
Baltimore, MD 21215-00: permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene. Important: If item 27 is marked other It migury or other traumatic event, the Med	70	19a. Informant's Name/Relationship (Type, Print) Misty Werner/Wife 19b. Mailing Address (Street and Number or 2300 Angle Drive,	Conove	r,Nort	h Ca	rolina ⁶¹
e, N l and Health item		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location	- City or T	own, State
Baltimore, permit. Pages 1 an Department of Hee Important: If itei		1 Burial 2 X Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Bass-Smith Crematory	2 22 0	Hickor	ov No	orthCarol
Baltin permit. P Departme Importan injury or	1	24 Signature of Europea Consider Lineague				
	2.3	muchael & granzuller 6009 Harford Ro	arzullo Sad, Bal	timore	Mar	yland212
Physician		23a. Part I. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.	or respiratory ar	rest, shock, or h	eart	Approximate Interval Between Onset and
'Medical ≟xaminer	ē	Immediate Cause (Final disease a Heroin Intoxication				Death
		or condition resulting in death) Due to (or as a consequence of):				
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
_	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated c. Due to (or as a consequence of):				
cuted and transit	Exa	events resulting in death) Last Due to (or as a consequence or): d.				
executan an an an an an	Medical	X UNPENDED				
760, cate be ex physician he burial		IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date	of delivery	
Box 687 ne death certific the attending r ned for use as the	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregr	nancy	Month	D	ay Year
Sox Jeath e e atter	ysic	1 Yes 2 No 9 Unknown Pregnant at time of death 5 Other (Specify)				
that the d ned by the detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did	tobacco use cor	ntribute to t	he cause of death?
, P.O. res that the signed by be detact	d by		1 Ye	es 2 No	3 Prob	ably 4 🗹 Unknown
Records, P.O. The law requires that the ficate has been signed by page 2 should be detach	Completed		24a. Was			opsy findings available ompletion of cause of
eco he law ite has age 2 sl	шc		perf	ormed?	death? 1 ✔ Ye	s 2 No
tal Ke cian: The certificate ector, page	a)	25. Was case referred to medical 26.Place of Death (Chec	ck only one)			
DIVISION OF VITAI Into Attending Physician: The after death. In Director: After this certi led in by the funeral director	To B	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 1 Nurs	sing Home 5	Residence 6	✓ Other	Scene
Ing Phy ling Phy After the	ī.	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?		how injury occi	urred	
ttend ttend death. ctor:	atic	Natural 5 Pending Pound 3/18/08 Found 10:45am Pending Investigation Found 3/18/08 Found 10:45am	Unknown			
IVE for A after Direct	Certification:	3 Suicide 6 X Could not be determined (Specify) Hatte 1 December 28. Place of Injury - At home, farm, street, factory, office building, etc.	or Town,	State)1.7∩1 I	211222	ral Route Number, City L Street
DIVI ospital or hours afte ineral Dir y filled in		4 Homicide (Green) HOLEL ROOM		<u> Baltimore</u>		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	nd due to the cau d at the time, date	use(s) and manr e and place, and	d due to the	e cause(s)
To T	Med	and manner stated. 29b. Signature and title of certifier 29c. License number				nth, Day, Year)
	-	Parcel Q May MA O.C.M.E.		March 19	, 2008	
		30. Name and agrees of person who completed cause of death (Item 23a)				
		Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore,	MD 21201			
		31. Date filed (Month, Day, Year) 7. Registrar's Signature				
Regis	trar					
HMH 17 Rev 1/2	001	ÖRIGINAL	C	CME		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State per Maryland / Demontory of Santh and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 18, 2008 10:50A MARCH HELEN GLADYS YENNEY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner KENT CHESTERTOWN CHESTER RIVER MANOR If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 X F 89 10/31/1918 MD Director 213-48-7366 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show "natural", or Items 23a or 28a-f shordical Examiner must be notified at 1 ☐ Yes 2 X No Director CHESTERTOWN MD KENT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21172 WYOMING AVE USA 21620 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ M No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygione. Important: If Item 27 is marked other than "natural" or iten any holury or other traumatic event, the Medical Examiner once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XIo Specify Specify: WHITE 9 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) OWN HOME HOMEMAKER 5 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ELISE R. BAUGHMAN HENRY F. STAUB 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21172 WYOMING AVE. CHESTERTOWN, MD 21620 DENISE DESTEFANO/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition X Burial 2 ☐ Cremation 3 □Removal from State BRENTWOOD, MD 4 ☐ Donation 5 ☐ Other (Specify) FT. LINCOLN 3/21/08 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 130 SPEER RD. CHESTERTOWN, MD 21620 Approximate Interval Between Onset and Death 23 Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 0 SRUS **Physician** QV V /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to (or as a conse gience of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed the attending physician and Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) o 9 I Inknown 9 Unknown ģ ۵ 23e. Did tobacco use contribute to the cause of death? certificate has been signed rector, page 2 should be def Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Vital Records. à law requires 1 Yes 2 No 3 Probably 4 Winknown an Completed 1095 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy The perform 2X No Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Shursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this Division or 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours a er deatl To the Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day Year) 29b. Signature and title 29c. License number

State

31. Date filed (Month,

Day, Year,

Registrar

DHMH 17 Rev 1/2001

and address of person who completed cause of death (Item 23a) (Type

trar's Signature

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Physician 7:55 A M MAMIE BORDLEY MARCH 2008 26 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner University of Maryland Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days 1 □ M XXF 215-34-8733 Usual Residence of Decedent 70 OCT 23 1937 MARYLAND Director with the Maryland r 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1X Yes 2 No Director MARYLAND N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or 3 U.S.A. by Funeral 1300 PENNSYLVANIA AVE. 21217 death 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examines once. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: BLACK 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) GENERAL LAB 10th grade N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be NATHIENAL TRIPP DORA MAE BATTS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy M. Johnson/Sister 4745 Maryknoll Rd., Baltimore, Maryland 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MT ZION CEMETERY 03-31-08 LANSDOWNE, MARYLAND 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE 21. Signature of Fyneral Service Licensee) della Coroun 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Metastatic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to influe diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

the Hospital or Attending Physician: within 24 hours a To the Funeral D completely

> State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Anospa Koshy, M.D.

2008

Baltimore MP 21201 32/Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ancopa Koshy, University of margland

29c. License number 18193

DEA: AU 417 6435218193

29d. Date signed (Month, Day, Year)

03

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year **Physician** 2008 MICHAEL WAYNE BOWSER MARCH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 0 rien 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1XM 2□ F Director 220-74-4982 SEPT 30 1958 MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the M-dical Examiner must be notified at Director MARYLAND HARFORD CO ABERDEEN 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 141 D HANOVER STREET 21001 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after Hygiene. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 🖾 No Baltimore, Maryland 21215-0036 Specify. Specify: BLACK ò 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If Item 27 is marked other than ' any injury or other traumatic event, the Me College (1-4or 5+) Elementary/Secondary (0-12) CONSTRUCTION 11th grade SELF 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be WILLIAM T BOWSER 2 MARY LOUISE BOWSER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RICHAE Gail Bowser/Sister 141 D. Hanover St., Aberdeen, Md., 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) METRO CREMATORY 04-02-08 BALTIMORE, MARYLAND 21. Sign / re of Funeral Service Licenses 22. Name and Address of Facility
WM C BROWN COMM FUNERAL HOME-HARFORD, Jarbara 321 S PHILADELPHIA BLVD, ABERDEEN, MD 21001 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical s a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-transit that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 2 □ No detached Ö 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? /es 2 No certificate 1□ Yes **Division or Vital** 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Deturing Home 5 Residence 6 Other (Specify) Hospital 1 TYes 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred After t or Attending 1 🔽 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 4 hours after death.

Funeral Director; A ely filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral D To the Hospital 15 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier who completed gause of deal (Item 23a) (Type, Print) 30. Name and address of person Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

(Month, Day, MAR 3

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 23a per dr., 8877; 03/31/08dbb 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 15, 2008 4c. County of Death Laura M. Bray March /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner lisbury Rehaba Nursing (Salisbur (Dicomico 8. Date of Birth (Month, Day, Oct. 15 9. Birthplace (State or Foreign Country)
Virginia If Under 1 Year | If Under 24 Hrs 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🛚 F Months Days Hours Oct. 224-18-4360 90 1917 Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 1 ☐Yes 2XNo MD Wicomico Delmar Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21875 United States 29539 Connelly Mill Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3X Widowed 4 ☐ Divorced Baltimore, Maryland 21215-00 Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pressure Packing Assembly Line Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ethel Lyons nee Unknown Robert Lyons ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 29539 Connelly Mill Rd., Delmar, MD 21875 Barbara J. Wood daughter 20b. Place of Disposition (Name of Cremeter scientary or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 3-19-2008 | Glen Burnie, MD Memorial Park re of Funeral Set 22. Name and Address of Facility Ambrose Funeral Home, Inc. any In 2719 Hammonds Fry Rd., Lansdowne, MD 21227 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Konik **Physician** /Medical Due to (or as a conse un nce of) Examiner vears Hypertension Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 (+No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check onl one Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 460 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manne Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 4 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200 Civic Ave. Sa Robins, m.D. lisbur William 2. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 3 1 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** ARGUERITE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deat Examiner sedal 0 Year If Under 24 Hrs. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Sex 5. Social Security Number **Funeral** Year) Days Months Hours 1 M 2 4 5 220-03-333 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notifled at 1 ☐ Yes 2 ☐ 10 Director BALTIMORE BALTIMORE 10g. Citizen of What Country? 10e. Street and Number SA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?. 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Hygiene. other than "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📆 No Specify Specify: WHITE ģ 3 Dividowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled w Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other trainmast. Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John George Dorsch Jr. Marie Urban 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3033 Edgewood Avenue; Baltimore, MD 21234 William J. Bittner Jr. - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem Gardens 3/29/08 Timonium, MD 4 ☐ Donation 15 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home Towson, MD 21204 23a. Part1. Enter the disease, or comportations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a cons wence of): Examiner erclusa Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ye to (or as a consequence of) Examiner The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): P.O. Box 68760, signed by the attending physician I be detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ð 1 🗌 Yes 2 No 3 Probably 4-Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 2 No filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 🔲 Inpatient this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: : After t To the Hospital or Attending within 24 hours after death.

To the Funeral Director, After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO 21234 Michael K. K.
31. Date filed (Month, Day, Year) State 2008 MAR 3

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) ate of Death 3. Time of Death **Physician** George Mason Bay /Medical 4a. Facility Name (If not institultion, give street and number) Town, or Location of Death Examiner Date of Birth (Month, Day, Year) 01-12-1924 9. Birthplace (State or Foreign **Funeral** M 2□F Days Months Hours 213-20-2930 84 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show notified at 1XYes 2 No Director MD Baltimore City 10e. Street and Number 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or any Injury or other traumatic event, the Medical Examiner must be 1 1708 Park Avenue USA 21217 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☆Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-00\$6 Specify: White Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Printing Paint Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walker Bay Addie Unknown ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sara Murnane / Friend 1717 Park Ave., Balt., MD 21217-4390 20b. Place of Disposition (Name of cemetery, crematory or other p Hilltop Service Corporation Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 03-31-2008 Towson, MD 4 □ Donation 5 □ Other (Specify) 22 Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service License 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** INFARCTION MYOCATONI 1047 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical as 1 attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1☐Live birth in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death After this certificate has been signed by the funeral director, page 2 should be detached 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by 4 Unknown CAROLD MY APA I HY 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an rmed 2 ☐ No 1□ Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 1 Inpatient 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury 5 Pending To the mospine within 24 hours after death.

To the Funeral Director: After the function of th investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of contifie 29c. License number 29d. Date signed (Month, Day, Year) M.O. D0061529

State

Registrar

MARK 31. Date filed (Month, Day, Year)

GOLDSTEIN Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAR 3 2008

ρ.

M.O.

SINAI

HOSPITAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 3/27/08 Pay **Physician** 2:28a Stephen C. Barnett /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Joseph Ritchie Hospice Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 42 214-92-3529 4/14/65 MD **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10b. County 10d. Inside City Limits N/A Baltimore MD 1 XYes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 USA 5915 Plummer Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. African 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No þ 3 Widowed 4 Divorced American Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Laborer 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wilton D. Barnett, Sr. Mildred Collins 19a. Informant's Name/Relationship (Type. Print)
Wilton Barnett, Jr./Brother 327 N. Ellwood Ave, Balt., MD 21224 19a. Informant's Name/Relationship (Type. Print) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 4/1/08 Baltimore, MD 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityHari P. Close F. Svs., PA 5126 Belair Rd, Balt., MD 21206-5105 22. Name and Address of FacilityHari P. 21. Signature of Funeral Service Licens 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Il cell carcine 4/2007 **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed: 25. Was case referred to medical examiner? Be (26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 24 hours a

Division or Vital Records, P.

 $rac{1}{2}$ $rac{1}{2}$ $rac{1}{2}$ $rac{1}{2}$ $rac{1}{2}$ $rac{1}{2}$ $rac{1}{2}$

0

3

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address

29b. Signature and title of certifier

>0 TTS: 1+ 32. Registrar's Signature

completed cause of death (Item 23a) (Type, Print)

ORIGINAL

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

)	\bigcirc	0	0	1	0	1	E.	
er.	0	U	0	ì	U		J	

ару воу віасі	KWCI	1-	For State Certificate of Death). No.	
Physic	ian/		egistrar Decedent's Name (First, Middle,Last)		2. Date of Death		3. Time of Death
ledical Exam			Baby Boy Blackwell		March 9, 20	008	1610 hrs
•		4	a. I domity I dame (in not motivated) give extent	wn, or Location of Death	1	4c. County of Deat	h
			314 South Monroe Street Baltimo		lo D (Pi-th	(MM/DD/YYYY) 9. Bi	rtholago (State or
Funera		5	. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under Months	Days Hours Min	ī. T	Forei	an l
Directo		:		unk unk un	k Mar 9,	2008	ountry Maryland
	7	-	Isual Residence of Decedent 10c. City. Town or Location				10d. Inside City Limits
w any	1	1	0a. State 10b. County 10c. City, Town or Location Baltimore				1 X Yes 2 No
Aaryland 28a-f show	غ ا	ξL		`ode	10	g. Citizen of What Co	untry?
Mary Mary	Director	<u> </u>	0e. Street and Number 314 S. Monroe Street	21223		USA	
5-0036 led within 72 hours after death with the Maryland slygiene. other than "natural", or items 23a or 28a-f she other than "natural", or items the notified at once		- 1		t of Hispanic Origin? (S	opecify Yes or No-		rican Indian, Black,
ath with the items 23a and he not	Funeral	֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֡֓֓֓֓֓֡֓֓֡֓֡	Armed Forces? If Yes, specify	Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	
er de		- 1	1 Yes 2 A No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2	X No specify:		Specify: b	Lack
urs afl tural	1 2	5⊢	45 Decedent's Education (Specify only highest grade completed) . 16a Decedent's Usual O	occupation (Give kind of ing life. DO NOT use re	work done	16b. Kind of Business	/Industry
5-0036 led within 72 hours after bygiene. other than "natural" Medical Framinal	Completed		Elementary/Secondary (0-12) College (1-4 or 5+)	ing life. DO 1401 dae re	urea		
036 ithin		5	none none none	T	ne (First, Middle, M	none	
			17. Father's Name (First, Middle, Last)	IIK			
21215-0036 buld be filed within 7 Mental Hygiene. marked other than	8	ו ב	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address	(Street and Number or	a Blackwe Rural Route Num	ELL ber, City or Town, Sta	te, Zip Code)
Shoul shoul N and N is m	£ 2	-	111 Dame			MD 21201	
≥ 5 5 5 6		1	20a. Method of Disposition 20b. Place of Disposition (Nam	e of cemetery,	Date	20c. Location - City	or Town, State
Ore ges l t of H			1 Burial 2 Cremation 3 Removal from State crematory or other place)				
Baltimore, permit. Pages I ar Department of He Important: If ite			4 Donation 5 X Other Specify: in state 21 Signature of Fundral Service Licensee / 22 Name and A	Address of Facility natomy Boar	1 655 U	Paltimore	Street
Baltimore permit. Pages 1 Department of 1 Important. If			119110120 2/1/1/1-727	-			
Physicia	_	1	23a. Part I. Enter the Aseasi, or complications that caused the death. Do not enter the mode of	f dying, such as cardiac	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
/ Medica	al	1	failure. List only one cause on each line. Immediate Cause (Final disease a. Drowning and Hypothermia				Death
tamine			or condition resulting in death) Due to (or as a consequence of):				
	١,		Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	9		cause. Enter Underlying Cause				
-0 :	_ 9	Xa	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
Ox 68760, eath certificate be executed attending physician and	- tran	<u>.</u>	d	0 / /1 /001-			
60, ate be ex hysiciar	Purral Si	Medical	X UNPENDED AMENDED 23a,27,28a-f per ME g878	5 4/1/06 amn		23d. Date of deliv	ery
876 ifficate	s the	2	23b. Was decedent pregnant in the 1 Live birth 2 Fetal death	3 Ectopic preg	nancy	Month	Day Year
Box 687 death certific	use s	Physician	past 12 months? 4 Pregnant at time of death 5 Other (Spec	cify)		T	
Bo ne dea the a	9 3	<u>~</u>	Part II. Other significant conditions contributing to death but not resulting in the underlying	cause given in Part I.	23e. Did to	obacco use contribute	to the cause of death?
that the	detact		Part II. Other significant conditions contributing to death but not resulting in the discerning	cauco gironini anni	1Ye	s 2 🗸 No 3 🔝 P	robably 4 Unknown
S, F quires	ald be	<u> </u>			24a. Was		autopsy findings available
Ord aw rec	2 shou	Completed				rmed? death	
Rec The 1	page	5		(D. 11 (Ob.)	1 Yes	2 No 1 🗸	Yes 2 No
tal	ector,	8	25. Was case reletted to friedical	26.Place of Death (Chec	rsing Home 5	Residence 6 ✔ O	her: Scene
Physic r this	al dir	0	1 V Yes 2 No	28c. Injury at Work?	-	how injury occurred	
n of	fune		1 Natural (Month, Day, Year)	1 Yes 2 X No	Rober 1 of	in toilat	
Sio Atten r death	by the	g	2 Accident Investigation 3/9/08 UNKNOWN 1 28e. Place of Injury - At home, farm, street, factory	, office building, etc.	28f. Location (in toilet (Street and Number or	Rural Route Number, City
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the rander death. al Director: After this certificate has been signed by	u pa	Certification:	Suicide Could not be determined (Specify) House		or Town, Baltimor	State)316 S Mon re. MD	roe Street
lospit t hour	ly Ell		29a. Certifier Continue Physician: To the best of my knowledge death occurred at the	e time, date and place, a	and due to the cau	se(s) and manner as	stated.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and	mplet	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my and manner stated.	y opinion, death occurre	ed at the time, date	e and place, and due to	o trie cause(s)
F. iv f.	8	₽	29b. Signature and title of certifier 29c	c. License number		29d. Date signed (
			and 2	O.C.M.E.		March 10, 200	
_		}	30. Name and address of person who completed cause of death (Item 23a)	Dollimore MD 040	201		
		_	Ana Rubio MD. Assistant Medical Examiner 111 Penn Street,	Baitimore, MD 212			
	Sta	ite	31. Date filed (Month, Day, Year) 2008 32. Registrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Roy Edgar Braly March 23, 2008 12:40 AMM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Augsburg Lutheran Home Baltimore Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Aug 19, 1919 9. Birthplace (State or Foreign Country) New Jersey 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☑ M 2 ☐ F 88 Yrs Director 147-01-1983 Usual Residence of Decedent e filed within 72 hours after death with the Maryland at Hygiene. other than "neturel", or Items 23a or 28a-1 show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "neturel", or Items 23s or 28s-f show 1 ☐ Yes 2 ☐ No Funeral Director MD Baltimore Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6825 Campfield Road #11G2 21207 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 XYes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🖸 No Specify: à Specify: white 3 Widowed 4 Divorced 142-145 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk unk Elementary/Secondary (0-12) College (1-4or 5+) 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Importent: If item 27 is marked othe any Injury or other treumetic event, once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Raymond Fielding Braly Ethel Christina Hasselbach 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jeanne Braly/spouse 6825 Campfield Road #11G2 Baltimore, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State

4 ☒ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board Baltimore, MD 21201 21. Signature of Funeral Service Licensee Ronald S Wade. Director 655 W. Baltimore Street und 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) THE ROSCLEROTIC ARDIO VASCULA **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ALLURI 1 Yes 2 No 3 Probably A Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 22 No 2 No 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 14 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After or Attending Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel C Hospite 1 Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number allani DE asireem 30. Name and address of persoft who completed cause of death (Item 23a) (Type, Print) AKHANI, 2835 SUITE SMITH ASNEEM 31. Date filed (Month, Day, Year) MAR 3 1 32. Registrar's Signature Complete ! State 2008

DHMH 17 Rev 1/2001

Registrar

192.5

David Butler 08-02164

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

NK UNK	1.	Sta State	ate of Marylar		rtment of		Mental Hy	/giene	20	008 1015
	R	egistrar . Decedent's Name (First, Middle	a Laet)	Cer	uncate or	Deam		2. Date of Deat	eg. No h	3. Time of Death
Physician/ al Examineد ا	-	Daily	BUT1 ER					Month March 17,	Day Year	1620 hrs
		a. Facility Name (if not institution	n, give street and num	nber)	4	b. City, Town, or L	ocation of Death	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	4c. County of E	
		2032 W. Saratoga Stre	eet			Baltimore			NI	7
Funeral	5	. Social Security Number	6. Sex 7	7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days		→		9. Birthplace (State or Foreign
Director	á	40-98-7784	1X M 2 F	4	19 Yrs.	Months Days	Hours Will.	MA9 1:	5, 1958	Country) N.C.
x	_	Jsual Residence of Decedent 0a. State 10b. County		10c City	Town or Location	nn				10d. Inside City Limits
ow any	1	oa. State Tob. County	1/10		-					1 Yes 2 No
Aaryland 28a-f show i at once.	<u>.</u>	0e. Street and Number	NIA	100	ACTIM	10f. Zip Code		11	0g. Citizen of What	Country?
the Maryland or 28a-f sh	ĕ ˈ		LANUALE	< -			26216		d.	50
with the Maryland ms 23a or 28a-f sho he notified at once brai Director		1. Marital Status		edent Ever in U	.S. 13. Was	Decedent of Hisp		ecify Yes or No	- 14. Race - A	American Indian, Black,
r death with or items 23		1 Never Married 2 X Ma	Armed For	rces?	If Ye	es, specify Cuban,	Mexican, Puerto	Rican, etc.)	White,	etc.
s after d		3 Widowed 4 Div	orced If Yes, Give Year	->		Yes 2 No				BLACK
hours after death with the Maryland hours after death with the Maryland Examiner must be notified at once end by Fundral Director		15. Decedent's Education (Spec				's Usual Occupati est of working life.			16b. Kind of Busin	ness/Industry
2 3 3 6	Jac	Elementary/Secondary (0-12)	College (1-	4 or 5+)					1000	2.0000 5:160
5-0036 lied within 72 hours a lightwither. t other than "natura the Medical Examin	Completed	7. Father's Name (First, Middle,	Last)	/R	MUTOR	nobile	18. Mother's Name	ONZ C (First, Middle, I	Maiden Surname)	FRIK SHOP
	oe De	JAMES E		110			MARTI		ERI	
		19a. Informant's Name/Relations		C/\	19b. Mailing	Address (Street	t and Number or F	Rural Route Nur	mber, City or Town,	State, Zip Code)
MD d 2 sho tth and n 27 is	k	VIUIM But	TUR! BA	orher	2850	W. LANG	ale 5%.	-Bair	20c. Location - C	1.21316
1 6 8 9 1	- 1	20a. Method of Disposition 1 Burial 2 X Cremation	3 Removal fro	I	Place of Disposi crematory or oth	er place)	"	,		•
MOTE Pages 1 nent of H ant: If i		4 Donation 5 Other St		A.	dient	Rem hine	Sexu 3/	27/08	HANOUER	nd.
Baltimore bermit. Pages 1 a Department of H Important: If it	1	21. Signature of Funeral Service	Licensee		22. N	ame and Address	of Facility 30	CRIN 7	Choma	CIRFLS
		23e. Part I. Enter the disease, or	Lemaie	(2)	di	100 201	maretol	W tol.	- Balter	md. 2/223
Physician Medical	ı,	failure. List only one cause	on each line.					or respiratory an	ost, offoot, of float	Between Onset and Death
kaminer		Immediate Cause (Final disease or condition resulting in death)	a. Pneumonia Due to (or as a			y) thermia				
	1	Sequentially list conditions,	b							
Š		if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a	consequence	of):					
W	티	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequence of	of):					
			d							
oe exe	alca dica	X UNPENDED	AMENDED 2	23a,27,28	8a-f per m	E g878 4/9)/08 amh			
Box 68760, s death certificate by the attending physical for use as the but the street of the but the street of th		F FEMALE: 3b. Was decedent pregnant in the	·	outcome of pre		tal death 3	Ectopic pregn	ancy	23d. Date of d Month	lelivery Day Year
c 68	cal	past 12 months?	I LIVE D	ant at time of d	a a th	tal death 3 her (Specify)	Ectopic pregn	arroy	Morra	Duy
BOy e death the att	S	1 Yes 2 No 9 Un	known 9 Unkno	wn						
P.O.		Part II. Other significant condit	tions contributing to	death but not	resulting in the u	inderlying cause o	given in Part I.			oute to the cause of death? Probably 4 ✔ Unknown
— s 50 s —	ed by							24a. Was		ere autopsy findings available
Division of Vital Records, lat or Attending Physician: The law requirer as after death. at Director. After this certificate has been similar in by the fameral director, page 2 should the strength of the fameral director.	Completed							auto	psy pr	rior to completion of cause of eath?
Rec The la	5		_					1 🗸 Yes		✓ Yes 2 No
ital Recician: The lician: The lician: The lician: The licians are sector, page	88	25. Was case referred to medica examiner?	Hearital:		7		Other Nursi		Residence 6 ✓	l Other Coope
FVit Physic er this	잍	1 Yes 2 No 27. Manner of Death	28a. Date	npatient 2	ER/Outpatient		ry at Work?	ing Home 5	how injury occurre	
n of hoting Ph. : After t	<u></u>	1 Natural 5 Pen	(Month	, Day,Year)			Yes 2 XNo			
Attencer death	<u>ë</u>	2 X Accident Inve	stigation FIIU 3/		Fnd 4:15 home, farm, stre	et, factory, office t	ouilding, etc.	28f, Location	(Street and Numbe	environmental col r or Rural Route Number, City
Divising pital or At pital or At ours after deral Direct filled in by	Certification:		Id not be rmined (Specify)	Found in	garage			2032 W S	^{State)} aratoga St,	Baltimore MD
Division 24 hours and a trend 25 hours and a feet death 5 Funeral Director: etely filled in by the		29a. Certifier 1 Certifying P	hvsician: To the bes	t of my knowle	dge, death occu	rred at the time, d	ate and place, an	d due to the cau	use(s) and manner	as stated.
To the Hos within 24 h To the Fun completely	힜	one) 2 Medical Exa	aminer: On the basis of and manner s	of examination	and/or investiga	tion, in my opinior	n, death occurred	at the time, date	e and place, and du	ue to the cause(s)
F S F O	ž	29b. Signature and title of certifi	er			29c. Licens				d (Month, Day, Year)
		Pote brow	rice-to	lla-	~	O.C.	M.E. 		March 18, 2	
i		30. Name and address of person				111 Donn C	treet, Baltimo	re MD 212	Ω1	
\		Patricia Aronica-Polla		ant Medical	ture a			,	- 1	
Stat Registra		31. Date filed (Month, Bay Year)	nno de	a A	Sperk					

08-02384 John J. Cardarelli		Please Type or Print in Black Indelib State of Maryland / Departme	le Ink. Ensure All Copi nt of Health and Mental I	i es Are Legi Hygiene		8 10159
	F	egistrar	e of Death	Reg.		3. Time of Death
Physician Medical Examin		1. Decedent's Name (First, Middle,Last) John J. Cardarelli		2. Date of Death Month 5 March 26, 2	Day Year 2008	1058 hrs
god k.		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea		4c. County of Death	
()		Franklin Square Hospital	Rosedale	To Date of Birth	Baltimore Cou	thplace (State or Foreign
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Months Days Hours M	in.	Co	untry)
Birector	-	212-58-0432 1 x M 2 F 54	Yrs.	11/05/	1953 Ma	ryland
any	l	10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
land f show	اق	Maryland Baltimore Middle		140	g. Citizen of What Cou	1 Yes 2 X No
Mary or 28a-	Director	10c. Street and Number	10f. Zip Code			indy:
		16 Slipstream Court 11. Marital Status 12. Was Decedent Ever in U.S.	21220 13. Was Decedent of Hispanic Origin? (Specify Yes or No-		ican Indian, Black,
death v	Funeral	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	White, etc.	
after o		3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 X No specify:	formati dana	Specify: 16b. Kind of Business	White
hours "natu		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	ecedent's Usual Occupation (Give kind or tring most of working life. DO NOT use r	etired)	Top. Kind of business.	muusty
336 thin 72 ne. than	Completed	9	a.		n/a	
215-0036 be filed within 7 trad Hygiene. 'ked other than ent, the Medica		17. Father's Name (First, Middle, Last)		me (First, Middle, Ma	aiden Surname)	
2121 nuld be fi Mental marked c event,	8	John Joseph Cardarelli 19a. Informant's Name/Relationship (Type, Print) 19b.	Mary Ro		ber. City or Town, Stat	e. Zip Code)
MD 2 nd 2 shoul ulth and N m 27 is n aumatic	의	, , , , , , , , , , , , , , , , , , , ,	5 Slipstream Court			
e, N 1 and 2 Health Health item	1		Disposition (Name of cemetery, y or other place)	Date	20c. Location - City o	r Town, State
MOF Pages ent of unt: If		Burial 2 A Cremation 3 Removal Iron State	w Crematory, Inc. 0	3/28/2008	Baltimore	, Maryland
Baltimore, permit. Pages I ar Department of He. Important: If ite injury or other tr	1	21. Signature of Europal Samoon Consee	22. Name and Address of Facility Bruzdzins 1407 Old Eastern	ki Funera	l Home, P.	A
	4	23a. Part V Enter the disease, or complications that caused the death. Do not	1407 Old Eastern enter the mode of dying, such as cardia	Avenue,	Essex, Mar st, shock, or heart	Approximate Interval
Physician Medical		failure. List only one cause on each line.				Between Onset and Death
vaminer	- 1	Im ediate Cause (Final disease or condition resulting in death) a. Methadone and all hull but to (or as a consequence of):	Intoxication			
	_	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				+
	Examiner	Course Critical Unidensity Cause C.				
and couted AN		events resulting in death) Last Due to (or as a consequence of): d.				1
executed ian and ial - transi	ica		8a-f per ME g878 4/15/0	08 amh		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial.		IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delive	
687 certifi anding	cian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic pre Other (Specify)	gnancy	Month	Day Year
Box le death c the atten	hysi	1 Yes 2 No 9 Unknown g Unknown			1	(1,-1,0)
P.O. ss that the sgned by be detach			in the underlying cause given in Part I.			o the cause of death? obably 4 Unknown
ds, F	Completed by	Emphysema with foreign body pulmonary gr	anulonas	24a. Was a	an 24b. Were	autopsy findings available
of Vital Records, g Physician: The law requir ther this certificate has been si meral director, page 2 should t	nple			autops perfor	med? death?	
Re iificate		25. Was case referred to medical	26.Place of Death (Che	1 Yes :	2 No 1	Yes 2 No
Vita ysiclar his cer directe	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Ou	tpatient 3 DOA Other Nu	rsing Home 5	Residence 6 Oth	ner:
of Ing Ph	\vdash	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. T	ime of Injury 28c. Injury at Work?	28d. Describe h	now injury occurred	
Division ital or Attendir ars after death. al Director: A	Certification:		10:25a 1 Yes 2 X No	Unk	Street and Number or I	Rural Route Number, City
Divis	ıţţi	Suicide 6 \(\Lambda \) Could not be determined (Specify) Formed at 1 and		or Town, S	itate)	le kiver MD 212
Hospit 4 hour Funers		29a. Certifier 1 Certifying Physician: To the best of my knowledge dea	th occurred at the time, date and place,	and due to the caus	e(s) and manner as st	ated.
o the lithin 2 o the loothe lo	Medical	one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurr	ed at the time, date	and place, and due to	the cause(s)
F > F 2	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (A	
		YM. W	O.C.M.E.		March 27, 200	
Ø		30. Name and address of person o completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 1	I1 Penn Street, Baltimore, MD	21201		
	ate trar		radio			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2008 **Physician** Ruth N. Cole /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Posedale Franklin Baltimora quare If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Dec. 01 6 Sex Age (In yrs. last birthday) **Funeral** Year Days Country) Maryland 1 □ M 2X F 96 217-20-3366 Dec. Director Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Dipartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumant event, the Medical Examiner must be notified at 1 ☐ Yes 2√ No Director Md. Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21236 USA 3737 E. Joppa Rd. Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Lole, ドルナル Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No 2 Specify. White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vance Cole Rebecca Frances Emory James 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9525 Burton Ave. Baltimore, Md. 21234 Mary Jane Potter/ Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 Removal from State Timonium, Md. Dulaney Valley Mem. 4-1-08 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Lic. 22. Name and Address of Facility Towson Funeral Home York Rd. Towson, Md 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) **Physician** 212 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of) sician and burial-transit be exect Due to (or as a consequence of) ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown cate has been siç , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 1□ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Inpatient 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier

P.O. Box 68760, Division or Vital Records, e Hospital or Attending Pl 24 hours after death. e Funeral Director: After the felety filled in by the funera To the Hospital or within 24 hours at To the Funeral D

🔀 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier

ES0000

29d. Date signed (Month, Day, Year)

Balto

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9000 FRANKLIN DR michele maRTIN

31. Date filed (Month, Day, Year)

MAR 3 2008

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Marylar		artment of Hertificate of L			ene () 0 8	10161
	Physic /Medi		1. Decedent's Name (First, Middle, Las		LVI	\sim		2. Date of Death		3. Time of Death
	Examir		4a. Facility Name (If not institution, give EASTERN CORRECT S. Social Security Number 6.	street and number) TIONAL x 7. Age (In yrs.	last hirthdayl	4b. City, Town, or WESTO If Under 1 Year	VEC	9 Date of Right	4c. County of De	SET
	Funeral Director		212 403317 2 Usual Residence of Decedent	20 F 64	Yrs.	Months Days	Hours Min.	8. Dat of Birth (Month, Day)	9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9	inthplace (State or Foreign Country) unk
	e Marylar Se-f ahow	ctor	MD Somerse		Westo					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	23a or 2	Funeral Director	10e. Street and Number 30420 Revells No	eck Road		10f. Zip Code	2189		g. Citizen of What C US	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than "natural", or iteme 23e or 28e-f ahow any injury or other traumatic avent, Ira Medical Examinational continual and ance.	by	11. Marital Status unk 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	unk '	Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2 X No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: b	ite, etc.
21215-0036	within 72 ho lene. then "natur te Medicel	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) unk	cation le completed) College (1-4or 5+)	(Give	dent's Usual Dccupa kind of work done di DO NOT use retired)	uring most of work	unk 1	6b. Kind of Busines	s/Industry unk
Maryland 2	buld be filed Mental Hyg arked other atic avent,	To Be C	17. Father's Name (First, Middle, Last)			unk	18. Mother's Name	e (First, Middle, M	aiden Sumame)	unk
	and 2 sh ealth and m 27 le m		19a. Informant's Name/Relationship (T Eastern Correcti	onal Institut	e 304:		Neck Roa	d Westov	City or Town, State, rer, MD 2	Zip Code) 21890
Baltimore,	t. Pages 1 tment of H tent; if Ite		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other Specify	Removal from State	cemetery, crer	sition (Name of natory or other place) 		Oc. Location - City of	
Ba	Dermi Depar Impo		21. Signature of Euneral Service Licent RONA Los S	Xee	Ba	Name and Address ate Anato	MD 2120	1_		1 0 1
	Physician /Medical		shork, or heart fillure. List only c Immediate Cause (Final disease or condition resulting in death)	ne cause on each line. a. MULTI OR	GAN		_	or respiratory arre	st,	Approximate Interval Between Onset and Death
報言	Examiner	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consect by DIAB ETE Due to (or as a consect by Due to (or as a consect by Diagram of the consect by Diagr	S					
90,	cate be executed physicien and the burial-transit	I Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. $\frac{HCV}{Due to (or as a consec}$		40- 7	2).(5 ~		(10.00
x 68760,		Medical	IF FEMALE:	d. ISCHEMIC		ART I	را را ال	77		6mo.
.O. Box	The law requires that the death certificate has been signed by the attending orage 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c 9 □ Unknown	al death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Dày Year
Records, P.	w requires that been signed k should be det	Ď	Part II. Other significant conditions co	ntributing to death but not res	sulting in the ur	nderlying cause give	n in Part I.	23e. Did tob	*	to the cause of death? Probably 4 □Unknown
		Completed						24a. Was an autopsy perform	ed? prior to	autopsy findings available completion of cause of us 2 No
Division of Vital	ding Ph J. After th funeral	atlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 100 27. Manner of Death Natural 5 Pending investigation	Hospital: 1 Inpatient 2 Inpatient 2 Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injury Work	r: 4 🗆 Nursing Ho	me 5 ☐ Resider 28d. Describe how	nce 6 Other (Sp	ecity PRISON
Divis	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, str	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or I State)	Rural Route Number,
	the Hoep in 24 hou the Fune ppletely fil	Medical	(Check only 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	owled e. death ation and/or inv	occurred at the time restigation, in my opi	e, date and place inion, death occurr	and due to the car ed at the time, da	ise s and manner a te and place, and di	es stated ue to the cause(s)
	To To Con	2	29b. Signature and title of certifier		MD	29c. License	number 25859	29	d. Date rigned (Mor	nth, Day, Year)
			DAVD MATA	115,30426	REI	Print) VELLS	NECK	RD, U	IESTOVE	R, M)
9.88.0 1.05.88.0	Sta Registr		31. Date filed (Month, Day, Year) 200	32. Registrar's Sign	ture	ME				21890

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Gloria Carpenter 2008 Certificate of Death Reg. No Registrar Time of Death 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 0840 hrs Medical Examiner Gloria Carpenter March 17, 2008 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) 1026 Woodson Road Apt. G **Baltimore** Birthplace (State or Foreign Country) 8. Date of Birth (MM/DD/YYYY) 5. Social Security Numberunk 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Country) Months Days Hours Min. Director 84 May 10, 1923 2X F Yrs M Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County Yes 2 No Baltimore 28a-f show or items 23a or 28a-f shormust be notified at once. death with the Maryland 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 1026 Woodson Road #G 21212 USA ā Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? White, etc. Never Married 2 Married Yes 2 X No Pages I and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene.

Sant: If item 27 is marked other than "natural", or or other traumatic event, the Medical Examiner in or other traumatic event, the Medical Examiner in Yes, Give Year Yes 2 X No specify: Specify: white Widowed Divorced ۾ 16a. Decedent's Usual Occupation (Give kind of work done nk 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 21215-0036 unk unk 18.Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) unk Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD Baltimore, MD 21201 Penn Street O.C.M.E. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery Date 20a. Method of Disposition crematory or other place) Burial 2 Cremation 3 Removal from State permit. Page:
Department o
Important: 1 in state Donation 5 X Other Specify: State Anatomy Board 655 W. Baltimore Street prature of Funeral S wade, 21201 Baltimore, MD pircations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Part I. Enter the disease, or con Physician Between Onset and failure. List only one cause on each line /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease [⊂]xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED tending physician use as the burial Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown ed by the detached f 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. o Part II. Other significant conditions Ś No 3 Probably 4 ✔ Unknown 1 Yes 2 ۵ Completed Records, has been s 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? certificate h Yes 2 V No 26.Place of Death (Check only one) Division of Vital 25. Was case referred to medical Be Other 4 examiner? lospital: 1 Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 Nursing Home 5 this 1 Yes 2 No After 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 V Natural 1 Yes 2 No Pending within 24 hours after death. Funeral Director: tely filled in by the 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier March 18, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Melissa Brassell, MD 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 03 **Physician** Year 230 PM 2008 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner tdventist Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F Months Director 93 219-36-8391 May 2, 1914 Washington, D.C. Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8811 Victory Lane filed within 72 hours after death Funeral 20854 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Completed by 3 Widowed 4 □ Divorced Specify: White "natural", the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental George J. Stevens Frances Craig 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t: if item 27 is r y or other traur Charles Butz / Nephew Marketree Court, Montgomery Village, Maryland 20886 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March 30. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. y Crematorium 2008 Bethesda, Maryland

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc., 7557 Wisconsin Ave.

Bethesda, Maryland 20814-3501 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium 21. Signat f Funeral Service L 29a. Part I. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due o (or as a consequence of) Examiner Myocarde Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sequence of): Examiner The law requires that the death certificate be executed burial-transit ehydration Due to (or as a consequence of) derebral vascular accident by Physician/Medical the IF FEMALE asn. 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2X No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. signed by the a d be detached f 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 No 1 Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No P this 1 🔀 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of After Certification: 28c. Injury at Work? 28d. Describe how injury occurred or Attending (Month, Day Year) Injury 1 X Natural 5 Pending investigation M 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours at To the Funeral C Hospital 24 hours a filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. le of certifier 29b. Signature ar 29c. License number 29d. Date signed (Month, Day, Year) 19 completed cause of death (Item 23a) (Type, Print) 30. Name and add

DHMH 17 Rev 1/2001

State Registrar

3001 Hospital Drive Cheverly, Maryland 20785

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month 4:45 P M March 25, 2008 Julia Marie Day /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Fairfield Nursing Center Crownsville Anne Arundel 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 □ M 2 🗓 F Hours 215-16-2873 86 Director June 4, 1921 Usual Residence of Decedent 10c. City, Town or Location works 10a. State 10d. Inside City Limits r 28a-f show notified at 1 LXYes 2 □ No Director Maryland n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 7 is marked other than "natural", or Items 23a or traumatic event, the Medical Examiner must be in 603 South Ann Street Apt 406 21231 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: by Specify: 3 N Widowed 4 Divorced 72 hours White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Federal Reserve Bank Accounts 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Simeon Sapliway Tatiana Solonuyika 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other trau Teresa Ann Day/daughter 532 Cleveland Road Linthicum, Maryland 21090 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crematory 3/29/2008 | Odenton, Maryland 21. Sign Pe of Funeral Service 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. tromas 1411 Annapolis Road Odenton, Maryland 21113 23a. Part1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** pronon disease or condition resulting in death) MIL /Medical sequence Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that the death certificate be executed aftending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐Live birth 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 2 No 0 ed by the 9 Unknown 9 Unknown م signed h Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 9 law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ► No 24a. Was an has autopsy performed? Yes 2 No The page certificate 1∐ Yes or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient Medical Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Division or Attending 5 Pending investigation 1 Natural Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death, 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of pe rson who completed cause of death (Item 23a) (Type, Print) 5 208 ina Registrar's Signature (Month, Day, State 2 Registra

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 9:45 P M DiAngelo 27 Betty May MARCH 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Futurecare Chesapeake Arno1d Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Ye. Oct. 16 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5 Social Security Number 6 Sex 6 1932 **Funeral** 1□M 2NF Yrs 75 Director <u>212-28-349</u>9 Oct. Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir then "netursi", or itsms 23a or 28a-f shov the Medical Examinar must be notified at 1 ☐ Yes 2 No Pasadena Director Maryland Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21122 IISA 7904 Low Tide Court death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Marned Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White δ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Giant Food Cashier 0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be is marked of Victoria Dise Bessie Milliron Henry Filson Louis 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (daughter) 7904 Low Tide Court, Pasadena, Maryland 21122 item 27 Kathleen M. Lascola 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location · City or Town, State 20a. Method of Disposition Department of H important: if ite sny injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 04/01/2008 Bayview Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 John de 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LUNG CARCINOMA METASTATIL /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for se's noneequence off Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit ding physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Day Year in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 ☐ Other (specify) 4☐ Pregnant at time of death 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autop sy performe 200 No 1 Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other:

Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA andir.
Tor: After th.
Turing a funeral direction 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending s after dem. 1 | Yes 2 | No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the P 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number mines 157531 March 28, 2028 mo 30. Name and address of petaon who completed cause of death (Item 23a) (Type, Print) mobit Negi 8661 millersville mi) Veterans Hwy 31. Date filed (Month, P 32 Registrar's Signature 2008 State Design ! Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of M	-	artment of Healt <i>rtificate of Dea</i>		Hygien Reg. N	2000	10165
	Dhysis		1. Decedent's Name (First, Midd	lle, Last)			2. Date Monti	of Death	ay Year	3. Time of Death
	Physici /Medi			James		Davis	3	26		10:25p M
	Examir	ner	4a. Facility Name (If not institution			4b. City, Town, or Locati	ion of Death	40	c. County of Death	
			Gilchrist Co		ge (In yrs. last birthday)	Towson	nder 24 Hrs R Date	of Birth	Balto	place (State or Foreign
	Funeral Director		246-14-4709 Usual Residence of Decedent	X X X X X X X X X X	87 Yrs.	Months Days Hou	urs Min. (Mont	of Birth h, Day, Year -5-19	20	N.C.
	ryfand how		10a. State 10b. County	,	10c. City, Town or Lo	ocation				10d. Inside City Limits
	e Ma 8a-f s	octo	MD	N/A	Baltimo	re				1. Yes 2 No
	vith th	ä	10e. Street and Number	- 1. Gb		10f. Zip Code			citizen of What Cour	ntry?
	eath v	erai	2029 E. 321	12 Was Decedent	Ever in U.S. 13	21218	Origin? (Specify Ves		U S A	can Indian
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinational control in the Medical Examination of the real particular or other traumatic event, the Medical Examination of the medical Examination of the medical examination of the	by Funeral Director	1 ☐ Never Married 2 ☐ Mar 3 🕱 Widowed 4 ☐ Divorced	Armed Forces? rried 1 ☐ Yes 2 1	No	Was Decedent of Hispanic If Yes, specify Cuban, Mex 1 □ Yes X□ No Spec		s.)	Black, White, Specify: B1	etc.
5-0	72 hc "natur	Completed	15. Deceder (Specify only highe	nt's Education est grade completed)	16a. Dece	dent's Usual Occupation kind of work done during r DO NOT use retired)	most of working	16b. l	Kind of Business/In	dustry
121	within iene. than "	dmc	Elementary/Secondary (0-12)	College (1-4or s	D+) ,			В	ethlehe	m Steel
	filed v Hygi Sther ent, th	Be Co	8th grade 17. Father's Name (First, Middle,		N/A Cra	in Operato) <u>r</u> lother's Name <i>(First, M</i>	iddle, Maide	n Surname)	
Maryland	Mental Merked of atic eve	To B	Richard Edwa	ard Davis		La	ssie Atk:	ins		
ary	2 should n and Mer is marke raumatic	ļ-	19a. Informant's Name/Relations	ship (Type. Print)	19b. Mailir	ng Address (Street and Nu	ımber or Rural Route N	lumber, City	or Town, State, Zij	Code)
	1 and 2 Health em 27		Maurice Day	vis - Son		N. Field		vwns		4032
lore	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 □ Cremation	3 ☐ Removal from State		sition (Name of natory or other place)	Date		Location - City or To	own, State
Baltimore,	Pa Inter		t Derial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		Woodla	wn Cem 2. Name and Address of Fa	4-1-2008		lto, MD	
Ba	Departr Imports any inju		1 Blady	a wan	ا ده	1101 E.	North Ave	enue		MD 21202
		n s	23a. Part 1. Enter the disease, of shock, or heart failure. List	r complications that caused only one cause on each li	the death. Do not ent					Approximate Interval Between Onset and Death
-1	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	_a	rastr	ve Hear	t face	erre		Jeans
7	Examiner			Due to (or as	a consequence of):	ve Hear	diseas	e		years
	ש. ב	ner	Sequentially list conditions, if any leading to mandiate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or se	a consequence of): /	,,,,,				1
	and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
68760,	rificate be executed by physician and as the burial-transit	a E	rooding in doday Edot	Due to (or as	a consequence of):					
687	ificate g phys	ledical		d						
Вох	eath cert attending for use s		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth		Ectopic pregnancy			23d. Date of deliv	
P.O. E	that the deaned by the a	Physician/N	1 Yes 2 No 9 Unknown	4 ☐ Pregnant a 9 ☐ Unknown	t time of death 5	Other (specify)		_	Month	Day Year
	es gi.	þ	Part in Other significant condition	ons contributing to death b	11 1	nderlying cause given in Pa		Did tobacco 1		he cause of death? bably 4 ☐ Unknown
eco	e law requir has been s je 2 should I	Completed	concer,	renal	insuff	liclency		Was an	24b. Were auto	ppsy findings available mpletion of cause of
<u>=</u>		Com	,		00			autopsy performed? es 2 N	death?	
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medica examiner?	Hospital:		045	lace of Death (Check of			11
of	Phys r this ral dii	5.	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ☐ Inpatie	ent 2 ER/Outpatien		Nursing Home 5		6 Other (Special	MHOSPICO
ioi	nding tth. :: Afte e fune	atior	1 ☑Natural 5 ☐ Pendin 2 ☐ Accident investi	g (Month, Da		28c. Injury at Work? M 1 ☐ Yes 2			2., 0000	
Division of Vital Records,	il or Atte after des i Director d in by th	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be lined 28e. Place of Inju- building, etc	ury - At home, farm, stre c. (Specify)	eet, factory, office	28f. Locati City o	on (Street a r Town, Stai	and Number or Rura te)	al Route Number,
	To the Hospital or Attending Pt within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical C	29a. Certifier 1 Certifylr (Check only one) 1 Medical	ng Physician: To the best Examiner: On the basis o and manner sta	f examination and/or in	n occurred at the time, date vestigation, in my opinion,	e and place, and due to death occurred at the	the cause(ime, date ar	(s) and manner as s nd place, and due t	stated. o the cause(s)
	To th To th comp	Me	29b. Signature and title of certifie	1 1 1	0	29c. License numb	per	29d. D	ate signed (Month,	Day, Year)
	1		March	of Kily	, cry	10252	203	Vui	mrch E	1,2008
	6		30. Name and address of person	who completed cause of d	eath (Item 23a) (Type, I	les St. fre	Go and	2170) k	
	Sta Registra		31. Date filed (Month, Day, Year) MAR 3 1 200	32. Registra	ar's Signature	,				

March 26,2008

James Davis

			For State Registrar	-	aryland / Depa	artment of Health and crificate of Death	Mental Hygi		10167
			Decedent's Name (First, Middle, Last))			2. Date of Death	1	3. Time of Death
	Physici /Medi		Samuel Lloyd Enso:	r			March	28 Year 200	8 2:17 PM
	Examir		4a. Fecility Name (If not institution, give			4b. City, Town, or Location of Dec	ath	4c. County of Dea	
			3 Firefly Cir., A			Cockeysville		Baltimo	
	Funeral Director		214-10-1047	X M 2□F 7. Ag	e (In yrs. last birthday) 87 Yrs.	If Under 1 Year If Under 24 Hours Mi		Year) 1920 Mar	thplace (State or Foreign ountry) 'yland
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation			10d. Inside City Limits
	Maryłan f show	ŏ	Maryland Baltimore	3	Cockeysvi	1110			1 ☐ Yes 2 No
	the rosa	Director	10e. Street and Number		Cockeysvi	10f. Zip Code	10	g. Citizen of What C	ountry?
	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28a-f show ha M. digal Examinar relial by notified at		3 Firefly Cir., Apr	t.E		21030	1	United Sta	ites
	deat	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S. 13.	Vas Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No-	14. Race - Am Black, Whi	
98	or its	F	1 ☐ Never Married 2 ☒ Married	Armed Forces? 1 X Yes 2 1 If Yes, Give	No	Tes, specify oddan, wextean, rue	rio moan, etc.)	Specify:	
8	ural',	d by	3 Widowed 4 Divorced	Year or Dates:	MM TT			W	hite
15-	n 72	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	(Give	lent's Usual Occupation kind of work done during most of w DO NOT use retired)	rorking	6b. Kind of Business	/Industry
12		m d	Elementary/Secondary (0-12)	College (1-4or 5	(i+)	gineer		electrica	a1
p	should be filed within 72 hours after death with the Maryla of Mental Hyglene. marked other than "natural", or items 23e or 28e-f show marked other than "natural", or items 22e or 28e-f show matic event, the Modical Examiner mail be notified at	BeC	17. Father's Name (First, Middle, Last)	D Jear.			ame (First, Middle, M	faiden Sumame)	
Jan	should be ind Mental I is marked or umatic eve	To B	Elmer En	nsor		Lilia	n Mav Ne	ppard	
ary	s 1 and 2 should if Health and Men item 27 is marke other traumatic	F	19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Mailir	g Address (Street and Number or i		4-4	Zip Code) 21030
Σ	Health tem 27 l		Myrtle Viola Ensor	(w		efly Cir. Apt.	E Cockeys	ville, Ma	ryland
Baltimore, Maryland 21215-0036	00		20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ F	Removal from State		sition (Name of natory or other place)		20c. Location - City or	
Ë	Pages iment of tent: If it jury or o		'4 ☐ Donation 5 ☐ Other (Specify)		Green Mou	nt Crematory Mar	. 29,2008 E	Baltimore,	Maryland
3all	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licens	PILIT	22 F11	Name and Address of Facility Joneral Services	ohn O. Mitc of Dulanev	1/2 1 0 77	ο Δ
	00560		23a. 7 nt.1. Enter the disease, or compl	ea		O E. Padolita Ku.	THIOHIC	ك كاتا واللا	0°93° Approximate
	Medical /Medical Examiner	Examiner	Affock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	1	SENOCARCINONI	4.		Interval Batween Onset and Death 4 Mox (WS.
. Box 68	that the death certificate bed by the attending physic detached for use as the b	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	d	2 Fetal death 3	lEctopic pregnancy Other (specify)		23d. Date of de Month	livery Day Year
rds, P	w requires that been signed should be detail	þ	Part II. Other significant conditions con	tributing to death bu	ut not resulting in the ur	nderlying cause given in Part I.	23e. Did tob	3/	o the cause of death?
Vital Records	e la has je 2	Completed	CORONARY ARC	tery 1	SIBEASE	ő.	24a. Was an autopsy perform	prior to death?	utopsy findings available completion of cause of
		ပိ	25. Was case referred to medical			26 Place of D	1 ☐ Yes 2 eath (Check only one	7	2 □ No
<u>></u>	S S	To B	examiner?	lospital:	nt 2 ER/Outpatien	Other	Home 5 Resider		ocify)
ion of	ing After une		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	ry 28b. Time of	28c. Injury at Work? M 1 ☐ Yes 2 🕱 No	28d. Describe how		,,
Division	al or Attending s after death. If Director: After od in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	ury - At home, farm, stre c. (Specify)	eet, factory, office	28f. Location (Str. City or Town,	eet and Number or R State)	ural Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical (29a. Certifier 1 Certifying Physical Check only one) 2 Medical Examin	sician: To the best oner: On the basis of and manner sta	examination and/or inv	occurred at the time, date and pla restigation, in my opinion, death oc	ce, and due to the ca curred at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	. 1		29c. License number	29	d. Date signed (Mgh	th, Day, Year)
}	,		Guc V	Shen	MD.	D25331	- Andrews	3/28/0	8
	6		30. Name and address of person who co	mpleted cause of de			SHOR	MA	
	•		7600 OSIER 1	DRIVE	suite	Print) BRIC FU 3/1 TOWSE	a, MA	RYIAND	21204
	Sta Registr	. 31	31. Date filed (Month, Day, Year) MAR 3 1 2008		ar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #26 State of Maryland / Department of Health and Mental Hygiene Per Phy G8// 3/31/08 JH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year Leon Everette Franks A M 03/24/2008 2:15 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6106 Rainbow Drive Elkridge Howard If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** M 2 ☐ F 415-26-7033 Director 80 10/2/1927 TN Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits Director MD Howard Elkridge 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be 6106 Rainbow Drive 21075 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. tryYes 2 □ No If Yes, Give 1 Never Married 2 Married altimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐XNo ģ Specify 3 ☐ Widowed 4 ☐ Divorced "natural", Year or Dates: Completed Item 27 is marked other than "natu other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Mobile Home Setter Housing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be file tment of Health and Mental Heart: If Item 27 is marked oth Be Horace Franks Julia Mitchell မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Franks Son 6106 Rainbow Drive, Elkridge, MD 21075 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If Ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 03/26/2008 Catonsville, MD 22. Name and Address of Facility
Gary L. Kaufman Funeral Home at MMP, INC.
7250 Washington Blvd., Elkridge, MD 21075 21. Signature of Funeral Service Licensee M01378 Quid Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): C. depreile Colitis Examiner Sequentially list conditions, it and be adding to in model cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner A thero sclerotic Cardio Vanuelar Diplan law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Diabetes Mellitus Division or Vital Records, P.O, Box 68760. physician Physician/Medical the attending p 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9 I Inknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1☐ Yes 2☐No director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: Nursing Home 5 Residence 6 ☐ Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No il or Attend after death. I Director: / 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) filled in by determined 4 ☐ Homicide within 24 hours at To the Funeral D Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 25 2008 D3064-1 30, Name and address of person who completed cause of death (Item 23a) (Type, Print)
Running Sabapathi 201-109 Back River Neck Road Bath more Mayland Uzzz 31. Date filed (Month, Day, Year) MAR 3 1 2008 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend, item 5 per fh 98/8 4-17-08 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician March 27,2008 Willie Ray Faison 9:11a M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Medical Center Cheverly Prince George's 5. Social Security Number 94 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9/22/1943 **Funeral** Birthplace (State or Foreign Country) 1**™** M 2□ F Months Days Hours 238-64-194 64 Director Wayne, N.C. Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f shor D.C. Director Washington 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1428 Euclid Street N.W. 20009 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: item 27 Is marked other than "natural", or items other traumatic event, the Medical Examiner man 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 should be filed within 72 hours after and Mental Hygiene.

Is marked other than "natural", or itel Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Completed by Specify. Black 3 Widowed 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Produce Worker Food Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unknown Cora Faison ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 st Health ar Mona Faison/Cousin 2962 Mills Avenue N.E. Washington, D.C. 20018 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other / Space 1 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages nent of I permit. Pages Department of Important: If it any Injury or o Carver Mem.Park 4/04/2008 Mt.Olive, N.C. 21. Signatur p Fungral Service Lice (Knift 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hypertension /Medical Due to (or as a consequence of): Examiner Asystole Sequentially list conditions, if any, leading to immediate cause. Enter undaring Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Chronic lymphoid leukemia and I-tran Due to (or as a consequence of): physician a Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2**K** No page certificate completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No Certification: To 1 X Inpatient this 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury after death 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number MD 035245 シと 3/28/2008 MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Hejl M.D. 1011 North Cap: 3 1011 North Capital St.N.W. Wash., D.C. 20002 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

08-02459 Mohsin Fida

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 10170

	- For State Capistrar	ertificate of Death	Reg. No.	
Physician/	1. Decedent's Name (First, Middle,Last) Mohsin Fida		2. Date of Death Month Day Y March 28, 2008	3. Time of Death 2055 hrs
Examiner	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Locati		y of Death
	University Hospital	Baltimore	Inder 24Hrs. 8. Date of Birth(MM/DD/YY	VVV 0 Rietholace (State or
Funeral Director		Months Days Ho	ours Min.	Foreign Countrakistan
	212-69-8858 1 X M 2 F 16 Usual Residence of Decedent	Yrs.	Dec.15,1991	THE TOTAL
any	10a. State 10b. County 10c. C	ity, Town or Location		10d. Inside City Limits 1 XYes 2 No
Maryland 28a-f show d at once. ector	MD.	Baltimore 10f. Zip Code	10g, Citizen of	
the Maryland a or 28a-f sh tified at once	10e. Street and Number 6509 Fairdel Ave.	21206	Pakis	
with the Maryland ns 23a or 28a-f sho be notified at once eral Director	11. Mantal Status 12. Was Decedent Ever in	n U.S. 13. Was Decedent of Hispanic	Origin? (Specify Yes or No- 14. Ra	ace - American Indian, Black,
or death with	1 Never Married 2 Married Armed Forces? 1 Yes 2X N	If Yes, specify Cuban, Mex	is and it is a second of the s	y: Asian
s after rral", o niner	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed	1 Yes 2 X No spe	···/·	Business/Industry
72 hour "natu ul Exar	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO I	NOT use retired)	
5-0036 ed within 72 hour hygiene than "natu he Medical Exan Completed	9	Student	S Cother's Name (First, Middle, Maiden Surna	chool me)
21215-0036 Juld be filed within 7 Mental Hygiene revent, the Medica TO BE Comple	17. Father's Name (First, Middle, Last) Fida Khan		Musarat Begum	
2121: hould be fil in a marked is marked attic event, To Be	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and	Number or Rural Route Number, City or T	
MD 2 strong 2 strong and 2 strong m 27 in auma	Fida Khan (Father) 20a. Method of Disposition	6509 Fairdel Av	e.,Baltimore,MD.212	on - City or Town, State
Baltimore, ME permit. Pages I and 2 si Department of Health as Important: If item 27 injury or other traums	1 Burial 2 Cremation 3 X Removal from State	crematory or other place)		,Pakistan
nit. Parartmen ortant	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	22. Name and Address of F.	acility Aden Muslim Fune	
Ba pern Dep Imju	Phillip Bill & 23a. Part I. Enter the disease, or complications that caused the de	1242 Easy St	Woodbridge VA 221	91 heart Approximate Interval
nysician Medical	failure. List only one cause on each line.		as cardiac or respiratory arrest, shock, or	Between Onset and Death
Examiner	Immediate Cause (Final disease or condition resulting in death) a. Head And Torso Inju			
	Sequentially list conditions, if any leading to immediate Due to (or as a consequen	on of):		
ied Insit	Cause Finier Underlying Gause			
Exar	events resulting in death) Last Due to (or as a consequent d.	ce of):	_	
r60, sale be executed physician and he burial - transit	UNPENDED AMENDED		W1 - 1774	
Aecords, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transi.	F FEMALE: 23c. If yes, outcome of 23b. Was decedent pregnant in the	5-1-1-1	23d. Datactopic pregnancy Mon	te of delivery th Day Year
Box 687 e death certific the attending p ed for use as th	past 12 months?	2		·
b. Box 687 the death certific the death certific by the attending sched for use as the Physician/	Part II. Other significant conditions contributing to death but	not resulting in the underlying cause giver	in Part I. 23e. Did tobacco use o	contribute to the cause of death?
P.O. s. that t. gned by e detac	Fait ii. Other significant conditions contributing to document			3 Probably 4 Unknown
Records, The law require, froate has been sig			autopsy	4b. Were autopsy findings available prior to completion of cause of
eco he law ate has age 2 s			performed? 1 ✓ Yes 2 No	death? 1 Yes 2 No
cian: T	25. Was case referred to medical examiner?		Death (Check only one)	6 Other:
f Vit Physic er this er al dire	examiner? 1 V Yes 2 No 27. Manner of Death Rospital: 1 V Inpatient 28a. Date of Injury	2 ER/Outpatient 3 DOA Other 28b. Time of Injury 28c. Injury at	Work? 28d Describe how injury o	ccurred
on o ending ath. or: Aft he fune tion;	1 Natural 5 Pending Mar 28, 2008	1312 hrs 1 Yes	2 No	to fixed object collision
Division of Vital Records, P.O. spital or Attending Physician: The law requires that th tours after death. neral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach. Certification: To Be Completed by P	Suicide Could not be	At home, farm, street, factory, office build	ing, etc. 28f. Location (Street and Nor Town, State) Belair Road & Fowler A	Number or Rural Route Number, City
Di spital hours a meral y filled Cerl	4 Homicide determined (Specify) Local S			
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as the Medical Certification; To Be Completed by Physician/I	29a. Certifier 1 Certifying Physician: To the best of my knot one) 2 Medical Examiner: On the basis of examinar and manner stated.	tion and/or investigation, in my opinion, de	ath occurred at the time, date and place,	and due to the cause(s)
To To Me	29b. Signature and title of certifier	29c. License nu		e signed (Month, Day, Year)
	Degrach Southerly MD	O.C.M.I	i warch	29, 2008
2	30. Name and address of person who completed cause of death Pamela E. Southall, MD Assistant Medical		Baltimore, MD 21201	
	31. Date fileds/Manth, Day, Year 2008			

		- For State		Certificate of		nd Mental H	Reg.	20 (10 101
Physician	_	legistrar 1. Decedent's Name (First, Midd	le,Last)				Date of Death Month D	ay Year	3. Time of Death 1300 hrs
lical Examin		Katherine S.		· · · · · · · · · · · · · · · · · · ·	4h City Tours	or Location of Death	March 14, 20	4c. County of Death	
	H	4a. Facility Name (if not instituti 1613 Four Georges (- · ·	r)	Dundalk	Location of Death		Baltimore Cou	
Funeral	7	5. Social Security Numberun		ge (In yrs. last birthday)	If Under 1 Ye	ar If Under 24Hrs	s. 8. Date of Birth(MM/DD/YYYY) 9. Bir Foreig	hplace (State ofunk
Director	١		1 M 2 X F	57 _Y	rs. Months Da	ys Hours Mir	Apr 21,	1950	untry)
	-	Usual Residence of Decedent							10d. Inside City Limit
w any	-	10a. State 10b. County	·	10c. City, Town or Loc Dund					1 Yes 2 N
yland -f sho	후		imore	Dana	10f. Zip Code		10g.	Citizen of What Cou	
e Mar	Director	10e. Street and Number 1612 Four Ge	orge's Cour	t B-2		1222		USA	•
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	틝		nk 12. Was Deceder	nt Ever in U.S. 13. V		lispanic Origin? (S			ican Indian, Black,
leath v	Funeral	1 Never Married 2	Married Armed Forces	2 X No	Yes, specify Cub	an, Mexican, Puert	o Rican, etc.)	White, etc.	
after c	by F		vorced If Yes, Give Yeer or Dates:	1	Yes 2X		17-17-		hite
hours natur Exami	ed t	15. Decedent's Education (Sp		during	ent's Usual Occup most of working li	ation (Give kind of fe. DO NOT use re	work dometnic 11	6b. Kind of Business	Industry unk
36 in 72 han "	訚	Elementary/Secondary (0-12 unk	College (1-4 o	r 5+)					
21215-0036 Mental Hygiene. marked other than it event, the Medica	Completed	17. Father's Name (First, Middl		l	unk	18.Mother's Nam	ie (First, Middle, Ma	iden Surname)	unk
215 be filed stal Hy ked o	Be								
21 bould b d Men is mar tic eve		19a. Informant's Name/Relation	ship (Type, Print)		, , ,			er, City or Town, Stat	e, Zip Code)
MC sk td 2 sk llth an m 27 i		O.C.M.E.		20b. Place of Disp			imore, MI	20c. Location - City o	Town, State
Baltimore, MD permit. Pages I and 2 sh Department of Health and Important: If item 27 is injury or other traumat	١	20a. Method of Disposition 1 Burial 2 Crematic	n 3 Removal from S			Sometory,	23.0	.,,	
Fage the fact that:			Specify: in state		Nome and Addre	nes of Facility	1 (55 77	D 165	Ctract
Bal permit Depar Impo injury		21. Signature of Euneral Service ROnal a	Wade, Di			тому Воат , MD <u>2120</u>		Baltimore	Street
Physician '	4	23. Part I. Enter the dinease,	or complications that cause	ed the death. Do not ente	er the mode of dyir	ng, such as cardiac	or respiratory arres	t, shock, or heart	Approximate Interview Between Onset an
/Medical		failure. List only one caus Immediate Cause (Final diseas	A+l 1	erotic Cardiova	scular Dis	sease			Death
⁻xaminer		or condition resulting in death)	Due to (or as a cor						
	Ļ	Sequentially list conditions,	b	accornance of):					
	xaminer	if any, leading to immediate cause. Enter Underlying Cause		isequence ory.					
g, g	Xan	(Disease or injury that initiated events resulting in death) Las	Due to (or as a cor	nsequence of):					
executed an and al - transi	alE	X UNPENDED	d.	Ba,27 per ME g8	878 4/24/06	R amb			
	sician/Medical	IF FEMALE:		come of pregnancy	7/0 4/24/00	- CHILL		23d. Date of delive	ry
Box 68760 re death certificate by the attending physical for use as the bu	an/N	23b. Was decedent pregnant in past 12 months?	the 1 Live birth	2	Fetal death	3 Ectopic preg	nancy	Month	Day Year
ath cer	sici	1 Yes 2 No 9 ✔ L	-language -	at time of death 5	Other (Specify)				
the de	Phy	Part II. Other significant cond	3 OTIKITOWIT	eath but not resulting in the	ne underlying caus	se given in Part I.	23e. Did tob	acco use contribute (o the cause of death?
P.O s that	þ	Tarin out of organization					1 Yes	2 🗸 No 3 🗌 Pr	obably 4 Unknow
ds, equire een si	eted						24a. Was a		autopsy findings availa completion of cause
COF law r has b e 2 sh	Completed						_ autops perforr 1 ✓ Yes 2	ned? death?	_
tal Records, P.O. Box rian: The law requires that the deatl certificate has been signed by the att ector, page 2 should be detached for		25. Was case referred to medi	nai T		26.PI	ace of Death (Ched		10	700 2
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Funeral Pirector: After this certificate has been signed by the attending physici lely filled in by the funeral director, page 2 should be detached for use as the buri	o Be	examiner?	I be a situate and	atient 2 ER/Outpati		Other		Residence 6 🗸 Oth	er: Scene
ing Phy After th	λ: Τ ο	27. Manner of Death	28a. Date of I	njury 28b. Time	· ' · _	njury at Work?	28d. Describe h	ow injury occurred	
Division of 'Hospital or Attending Ph 24 hours after death. Funeral Director: After t	Certification:		nding			Yes 2 No			
W 2 9 5 5	ၓ	- Normanii III	Conganon	f Injury - At home, farm, s	troot factory offic	se building etc	28f Location (S	reet and Number or	Rural Route Number, (

State 31. Date filed (Month, Day, Year) Registrar 29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

March 15, 2008

and manner stated.

Assistant Medical Examiner

32. Registrar's Signature

30. Nat e and address of person who completed cause of death (Item 23a)

2008

Margarita Korell MD.

Certificate of Death

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** March 28, 2008 10:20 A M Wan-Mei Fan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Montgomery Rockville If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🛛 F 87 220-94-5860 Director July 21, 1920|Taiwan Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits if Hygiene. other than "natural" or items 23a or 28a-f show vent, the Medkeal Examiner must be notified at 1 X Yes 2 No Directo Maryland | Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8836 Mourning Dove Court 20879 United States by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Asian 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If item 27 is marked other tt any injury or other traumatic event, the once. Hospitality <u> Hotel</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lou Ah Hai Chang Chan Mei 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lan-Ying Brown/Daughter 8901 Centerway Road, Gaithersburg, MD 20879 20b. Place of Disposition (Name of cemetery, crematory or other place Parklawn Memorial April 4, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rockville, MD Park 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, MD 20850 21. Signature of Funeral Service Licensee M01346 23a. Part1. Emil the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hyperosmolar Nonketonic Coma 1 Day /Medical Due to (or as a consequence of): Examiner Acute Renal Failure 1 Day Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Type II Diabetes Mellitus Years attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Hypokalemia, Congestive Heart Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy perform 2 👿 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) march 28,2008

DHMH 17 Rev 1/2001

State Registrar

Grach !

9901 Medical Center Dr., Rockville, MD 20850

address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

- YAO

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year CLIFTON 700 PM GOLDEN MARCH 21 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 9401 Sixth Street N. Laure1 If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Yea Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1XX M 2 □ F Director 213-24-3702 79 Feb. 12, 1929 Maryland Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f sh Examiner must be notified Directo Maryland Howard Laurel 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9401 Sixth Street N. 20723 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner must vonce. Funeral 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White δ 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner Western Auto 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Alma Golden Sarah Priscilla Posey 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Golden Raley- daughter 19151 Lake Drive, Valley Lee, MD 20692 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cemetery March 28,2008 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Fleck Funeral Home, INC. Man 7601 Sandy Spring Rd., Laurel, MD 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CONGESTIVE HEART Z MONTHS FAICURE /Medical Due to (or as a consequence of): Examiner DIABERS Sequentially list conditions, if any, leading to intrivediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed HYPENTENSION physician and s the burial-trans TEAMS Due to (or as a consequence of) Records, P.O. Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖼 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? 2 No 2□ No Division or Vital 1∐ Yes the Hospital or Attending Physician: director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐No 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Affer 5 □ Pending investigation 1 Matural Injury 1 ☐ Yes 2 ☐ No after death 2 Accident in by the 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide / filled i Medical 29a. Certifier 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

24 hours a within 2

> State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

MAR 3 2008

ROBERT MAGGIN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



mo

13952 BOTTMONE BUE. CONNEC

29c. License number

D22455

29d. Date signed (Month, Day, Year)

MANCH 24, 2008

20707

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month Year 7: CO A M Dorothy W. Gladue MARCH 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HOSPITAL AGNES BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🗙 F 219-03-5698 Director 88 July 3, 1919 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Fyamina. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☑ Yes 2 ☐ No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 701 Brookwood Road 21229 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. ģ Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Medical Clerical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (John E. Whittington Mary Callahan ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Gladue 701 Brookwood Road; Baltimore, Maryland 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) hedral 3/31/2008 Baltimo
22. Name and Address of Facility Sterling Ashton
Funeral Home of Catonsville, Inc. New Cathedral Baltimore, Maryland Ashton Schwab Witzke Signature of Funeral Service Licens on M M01490 1630 Edmondson Avenue; Catonsville MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ADRTIC STENOSIS CRITICAL 2475 /Medical Due to (or as a consequence of): **Examiner** ATRIAL FIBRILLATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed KIDIVEY CHRONIC DISEASE -STAGE Due to (or as a consequence of): P.O. Box 68760, Physician/Medical CONGESTIVE FAILURE HEART IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Dav 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Jas autopsy perform certificate 2 No Division or Vital Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation or Attending 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hin 24 hours at the Funeral D npletely filled in 1 🖫 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar

Medical

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAR 3 1

PULICKEN, 900 S. CATON AVENUE, BALTIMORE, MD 21229 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

within 2.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

P 2180 0

29d. Date signed (Month, Day, Year)

27,2008

MARCH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Not ... 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 Month Physician March 19, 1:00 РМ Jerome Grossman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hebrew Home - Greater Washington Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year)
Nov. 15, 1921 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1 X M 2 □ F Director 86 073-16-1980 Usual Residence of Decedent r 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🛛 No Director Rockville Maryland Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? "natural", or items 23a or dical Examiner must be 20852 United States 6121 Montrose Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No ģ Specify 3 ☐ Widowed 4 ☐ Divorced Caucasian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Insurance Insurance Executive Department of Health and Mental Hygie Important: If item 27 Is marked other any injury or other traumatic event, tt once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Irving Grossman Ethel Cohen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose C. Grossman - Spouse 1801 E. Jefferson St. #607 Rockville, MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) King Dayid Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mar. 21, 2008 Falls Church, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Jefferson Funeral Chapel 5755 Castlewellan Dr. Alexandria, VA 22315 23a. Hart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** o (or as a consequence of): /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 D I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No 1□ Yes Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → No ဥ 2 ER/Outpatient 3 DOA ō nours after death.

neral Director: After this

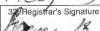
filled in by the funeral di 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 14 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral C completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type_Print)

20

State Registrar 31. Date filed (Month, Day, Year)
MAR 3 1 2008

INESH



MA

D 6121 MONTRUSE 12D, ure

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **Physicia**

/Medica Examine **Funeral** Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. Pd Kilony AS Anthony Baltimore, Maryland 21215-0036 0000 **Physician** /Medical

Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran

> State Registrar

	1- State Registrar Certificate of Death Reg. No. 2008 0 76									1 5	
	1. Decedent's Name (First, Middle, Last) 2. Date of D Month						h	V	3. Time of Death	1	
ian cal	Anthony T. Gross		MARCH	Jay	2008	2:22 A	М				
ner	4a. Facility Name (If not institution, give street and num	4b. City, Town, or Location of Death					ty of Death				
	5 Social Security Number 6. Sex	timore	Baltimore			0.00	N/2				
	212-44-5638 12 M 2 F	7. Age (In yrs. last birthday) 61 Yrs.	Months Days Hours M		Min.	8. Date of Birth (Month, Day,				ign	
	Usual Residence of Decedent	01			<u>R</u>	3/23/ 4	7		4D	-	
	10a. State 10b. County MD N/A	cation						10d. Inside City Limi			
55	MD N/A Baltimore								X □Yes 2□N	10	
ă	10e. Street and Number		10f. Zip Code			1	0g. Citizen o	f What Cou	ntry?		
eral	3908 Groveland Avenue				-i-0 (0	-it. V N	USA		an Indian		
Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Ves 1 □ Yes 3 □ Widowed 4 □ Divorced 1 □ Yes 6 □ If Yes, Give	ces? I	J.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 No Specify:					ace - Americ ack, White, cify: Afri	etc.		
ted	15. Decedent's Education	16a. Deced	ent's Usual Occupa		- 1	American 16b. Kind of Business/Industry					
ble	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1	4or 5+) (Give life. E	kind of work done o OO NOT use retired	furing most)	t of workir	ng C	onst	nstruction			
Sol	12	Labe	rors								
8e	17. Father's Name (First, Middle, Last)					(First, Middle, M Queen	Maiden Surna	ame)			
2	James Gross										
	19a. Informant's Name/Relationship (Type. Print) Cassandra Gross/Daugh	ter 1518	g Address (Street a	ina Numbe inato	or Hura On S	Houte Number, StBal	City or Tow	n, State, Zip	223		
	20a. Method of Disposition						20c. Location				
П	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Mt. Zion Cem 20c. Location - City or Town, State Lansdowne, MD										
	21. Signature of Funer, Service Licensee 22. Name and Address of Facility Hari P. Close F.Svs, PA 5126 Belair RD, Balt., MD 21206-5105										
	23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate										
9 9	Immediate Cause (Final										
	disease or condition resulting in death) a. Myccardia Infarction Due to (or as a consequence of): Sequentially list conditions, b. Coronary Artery Disease										
	Sequentially list conditions, b. Due to (o.	Coronary	Artery Di	Sease							
Examine	if any, leading to immediate Due to (or as a consequence of :										
xan	that initiated events c	r as a consequence of):	e of):								
dical											
ledi											
Completed by Physician/Me	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 2 so. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 23d. D M M M M M M M M M							ate of delive	ate of delivery		
sicia								Month Day Year			
Phy											
l by							23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown				
etec	Hypertension Asthma										
ршо	Itsthma						24a. Was an autopsy performed 24b. Were autopsy findings avait prior to completion of cause death?			le f	
	1										
o Be	26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)										
L:uc	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred										
atic	2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No										
řtifi	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number of Town, State) 28f. Location (Street and Number or Rural Route Number of Town, State)								al Route Number,		
<u>ا د</u>	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									,l.'	
Medical Certification: To	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
Σ	29b. Signature and title of certifier					d. Date signed (Month, Day, Year)					
						March 22, 2008					
	30. Name and address of person who completed cause			Q. 11.		Ma a	سرر ور				
te	31. Date filed (Month, Day, Year) 32 Reg	2401 W Belved gistrar's Signature	erc MVE	DAIT	more	TIB Z	12/3			_	
ar	MAR 3 1 2008	was St Age	els)								

1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Melda March 18 Grose /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frostburg Inder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Nov 1, 1916 Allegany 9. Birthplace (State or Foreign Country) Frostburg Village Nursing Home 5. Social Security Number (In yrs. last birthday) **Funeral** Months 1 □ M 2 🖸 F 91 Director <u>215-14-6160</u> Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a, State 10b. County MD Allegany Director Frostburg 10e. Street and Number 10f. Zip Code 1 Kaylor Circle 21532 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No ģ 3 XWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) teacher aide 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cecil Engle Jane Davis ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Engle/nephew 19020 National Highway Frostburg, MD 21532 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licenses 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part1. Enter the ckease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) DEMENTIA **Physician** /Medical Due to (or as a consequence of): Examiner MOTER CARRE Schooliely Lit conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit the HospItal or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending properties for use as IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 4□Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u></u> Completed 24a. Was an 2 No 1∐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 5 Pending investigation 1 Natural Injury thours after death. uneral Director: Af ely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho To the Fun completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

> 1 ☐ Yes 2√ No 10g. Citizen of What Country? USA 14. Race - American Indian Black, White, etc. Specify: white 16b. Kind of Business/Industry <u>education</u> Approximate Interval Between Onset and Death about 10 year 23d. Date of delivery Month Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
> 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) MARGIN 24 Cumberland, MD 21502

Year

Maryland

2008

Рм

1:15

10d. Inside City Limits

State Registrar

29b. Signature and title of certifier

Har jit S. Sidhu 31. Date filed (Month, Day, Year)

9 theolher

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

925 Bishop Walsh RD.
32 Registrar's Signature

29c. License number

116907

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month MARCH BERNARD 2008 GILDEN 04:05AM /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 ☑ M 2 ☐ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 213-20-9011 Director 83 12/16/1924 MD Usual Residence of Decedent death with the Maryland r 28a-f show notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be re 6508 COPPERFIELD ROAD 21209 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Dayes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: WHITE ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWNER **GROCERY STORE** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MAX GILDEN ZELDA YAVITZ ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6508 COPPERFIELD RD., BALTIMORE, MD 21209
Disposition (Name of Date 20c. Location - City or Town, Sta SHIRLEY GILDEN / WIFE 20b. Place of Disposition (Name of BECPINETED Crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) MĒMORĪĀL PARK 03/28/2008 RANDALLSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Mell 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CARDIOGENIC SHOCK /Medical Due to (or as a consequence of): **Examiner** SEVERE CARDIOMYOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-transit Due to (or as a consequence of) Box 68760, attending physician Physician/Medical as the l IF FEMALE: use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) P.O. signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 END STAGE RENAL FAILURE 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an has page 2 autopsy perform certificate 2 No 1 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: the Hospital or Attending 1 Natural 2 Accident 5 ☐ Pending investigation Iniury within 24 hours and to to the Funeral Director: Af 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 2 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) D24034 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIMOTHY LOW. M. D. 7601 OSLER DRIVE TOWSON. MARYLAND 21204 31. Date filed (Month, Day, Year) 32 State

DHMH 17 Rev 1/2001

Registrar

MAR 3

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			For	State of Marylan	d / Depa	artment of H	lealth and	Mental Hygi	•	10170	
			1 - For State Registrar		Ce	rtificate of	Death		g. No. UUO	10179	
	Physici /Medio		1. Decedent's Name (First, Middle, Last,	TH HUC	SHES	5-5EN		71111-011	30, 2008	3. Time of Death 9,35A	
	Examir	er	4a. Facility Name (If not institution, give		L	_	r Location of Dea	ith	4c. County of Dea		
	Funeral		Hebrew Home of 6 5. Social Security Number 6. Sec			If Under 1 Year	CKVILLE If Under 24 Hr	s. 8. Date of Birth	Monta 9. Bir	thplace (State or Foreign	
П	Director		115-28-5631 15	M 200 F 71	Yrs.	Months Days	Hours Mir	October 1	Year) Co	Jew York	
	d oth		Usual Residence of Decedent 10a. State 10b. County	10a Cin	y, Town or Lo						
		ō	Maryland Montgon							10d. Inside City Limits 1 ☐ Yes 2 🗷 No	
		rect	10e. Street and Number	1019	4 CLI+	hersburg		10	g. Citizen of What Co	ountry?	
		Funeral Director	503 A S. Frederic	K Avenue Apt	4.	,	877		US	SA	
		Iner		12. Was Decedent Ever in U.: Armed Forces?	S. 13.	Was Decedent of H	lispanic Origin? (Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whit		
36		by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	Married 2 Married 1 Yes 2 No			Specify:				
8		Be Completed	15. Decedent's Edu	Year or Dates:	16a. Dece	dent's Usual Occup	pation	1	6b. Kind of Business		
21215-0036			(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of w	orking		,	
7			12		<u></u>	Bank	Telle		Finan	cial	
Maryland			17. Father's Name (First, Middle, Last)	ala a a				me (First, Middle, M	_		
2	hould Id Mei mark	ဥ	Victor Hug 19a. Informant's Name/Relationship (Ty		19h Mailir	on Address /Street			Deveal.		
Σ	nd 2 s lith an 27 ie r trsu		Audrey Capender			ee Wor				D 20878	
ore,	os 1 au of Hea itam othe		20a. Method of Disposition		lace of Dispo	sition (Name of matory or other place			0c. Location - City or		
Ĕ	Page ment a ant: if ury o		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☑ Donation 5 ☐ Other (Specify)	emoval from State a	ctomu Gi	Cts Regist	ry March	30,2008 7	tanover in		
Baltimore,	Depart Import eny in		21. Signature of Juneral Service License		22	. Name an Taddre	of Facility Av	atomy 61	Hi Registr	XID 21076	
	403 8 d	-	23a. Part1. Enter the disease, or compli	cations that caused the death	7 !	522 Conn	elley Dr	ive SuiteP	Hanover,	MD 21076 Approximate	
E	Physician /Medical Examiner		shock, or heart failure. List only or	e cause on each line.	_	-			St,	Interval Between Onset and Death	
			Immediate Cause (Final disease or condition resulting in death) a. MDLIGNANT LUNG NEOPLAS M Dyeylo (ox as a consequence of):								
			Sequentially list conditions	((0)V)							
_	ed sit	liner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
Z2.	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c							
	w 2 0	cal									
89	death certificat e attending phy d for use as th	Medi	IF FEMALE:								
Вох	Itendi or use	lan/	23b. Was decedent pregnant in the past 12 months?	decedent pregnant 23c. If yes, outcome of pregnancy						23d. Date of delivery Month Day Year	
o	that the de led by the a detached i	Physician/Med	1 ☐ Yes 2 ☑/No 9 ☐ Unknown	4☐ Pregnant at time of de 9☐ Unknown	eath 5∟	Other (specify) _					
ت. ت	s that	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute I							the cause of death?	
Hecords,	w requires been sign should be							1 ☐ Yes	2 □ No 3 □ Pr	robably 4 Whiknown	
ဝင္	The law requires that te has been signed b age 2 should be deta	Completed						24a. Was an	24b. Were at	utopsy findings available completion of cause of	
	(G (T	Con						perform 1 Yes 2	ed? death? ☑No 1 ☐ Yes	1/	
Vital	rnysician: In this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		Oth	or 1	ath Check only one	0		
	ng Phys ter this neral di	2: 70	27. Man or of Death	1 Inpatient 2 E	ER/Outpation 28b. Time of	t_3L_DOA	47 Nursing	Home 5 Resider	nce 6 Other (Spe vinjury occurred	cify)	
0	Attending I r death. ector: After by the funer	atloi	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury North 28c. Injury-at Work? 1 Yes 2 No							
	after deati	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, str	eet, factory, office		28t. Location (Stre	eet and Number or Ri State)	ural Route Number,	
ַ	nospital or 24 hours afte Funeral Dir tely filled in		29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
:	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	Medical	(Check only one)	er: On the basis of examinati and manner stated.	wledge, death ion and/or inv	occurred at the ting restigation, in my o	ne, date and plac pinion, death occ	e, and due to the cau urred at the time, dai	use(s) and manner as te and place, and due	s stated. e to the cause(s)	
	vithin 2 To the complet	Σ	29b. Signature and title of certifier	Hallen.	M.	29c. Licenso	3543		d. Date signed (Mont	h, Day, Year)	
		-	Dangue	queenny	00.15	1	ノフィン	o M	MICH	4020857	
	\		30 Name and address of person wing co	The Cause of death (Hem	6 / C	THONT	ROSER	P,RICK	VILLE,	MD 2085Z	
ŧ,	Stat Registra		31. Date filed (Month, Day, Year) MAR 3 1 20	32. Registrar's Signati	k d	selle					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | | | | | | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Year March 24, 9:00 P^M Victoria Hood 2008 <u>Matilda</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4824 Country Court Ellicott City Howard If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🛣 F Yrs. Director Virginia 230-12-2087 88 Nov 13, 1919 Usual Residence of Decedent with the Maryland 10a. State rthan "naturat", or Items 23s or 28s-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Directo Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death v 4824 Country Court United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after ☐Yes 2XNo 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Specify: Year or Dates White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) United States College (1-4or 5+) 12 Clerk Postal Service permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: if item 27 Is marked oth any linjury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Alton Williams Rose Ann Bledsoe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 4824 Country Court Ellicott City, Maryland 21042 Taylor Asbury Hood, Jr./husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Good Shepherd Cemetery 3/28/2008 Ellicott City, MD 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 21. Signature of Funeral Service Licensee ucinta R Phomas 1411 Annapolis Road Odenton, Maryland 21113 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Chronic Obstructive Pulmonary Disease 10+ years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): d. The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Physician/Medical the as attending IF FEMALE use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery ō 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Coronary Artery Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peed 24b. Were autopsy findings available prior to completion of cause of death? Compli 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 2 1 ☐ Yes 2 🔀 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending 1 XNatural Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) m D0015144 March 25, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

19

Registrar

State

Luke E. Terry, Jr.

MAR 3 1 2008

31. Date filed (Month, Day, Year)

Box 68760,

Records, P.O.

Division of Vital

32. Registrar's Signature

A BOULER

9055 Chevrolet Drive Ellicott City, Maryland 21042

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Paul Thomas Harris, Sr. March 28, 2008 8:10 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7 Central Avenue Baltimore Glyndon If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. | Dec. 9, 1933 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Sex 1☑ M 2☐ F 74 Pennsylvania 215-30-5600 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

Is marked other than "natural" or items 23a or 28a-4 show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Baltimore Glyndon 1 ☐ Yes 2 🛣 No Maryland Director 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 7 Central Ave. 21071 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry State of Maryland College (1-4or 5+) Elementary/Secondary (0-12) Transportation Procurement Officer permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nesbitt Harris Grace 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Harris - wife 7 Central Ave. Glyndon, MD. 21071 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Evergreen Mem. Gardens April 1,2008 Finksburg, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD. 21117 Approximate interval Between Opera and De 23a. Part1. Enter the disease, or complications in treasused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, translate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 2X No 3 Probably 4 ☐Unknown 1 ☐ Yes Completed Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an

After this certificate Funeral Director:

Be

Certification: To

Medical

and address of

autopsy perform 1∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 100 Other: 4 \sum Nursing Home 1 Yes 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Inpatient 5 Residence 6 Other (Specify) Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

Date filed (Month, Day, Year) MAR 3



hours

To the

29c. License number

29d. Date signed (Month.

Day, Year,

ennis J. Holland		I- For State	tate of Maryla	and / Dep		Health and			20	08 1018			
Physiciai Medical Examin	n/	Registrar 1. Decedent's Name (First, Mid Dennis		olland				2. Date of Dea Month March 26	Dav Year	3. Time of Death 1555 hrs			
(A)		4a. Facility Name (if not institut				4b. City, Town, or t	ocation of De		4c. County of De				
Funeral Director		5. Social Security Number 223–66–4508	6. Sex	7. Age (In yrs	. last birthday) Yrs	If Under 1 Year Months Days			13, 1957 Fo	Birthplace (State or eign Country)			
ow any	-	Usual Residence of Decedent 10a. State 10b. County MD Anne.			y, Town or Locat					10d. Inside City Limits 1 Yes 2 X No			
ne Maryland or 28a-f show iffed at once.	Director	10e. Street and Number 553 Munroe Ci	Arundel Ircle		ilen Buri	10f. Zip Code 21160			10g. Citizen of What C				
	L	11. Marital Status 1 Never Married 2	Married 1 X Yes	2 No	If Y	es, specify Cuban,	Mexican, Pue	(Specify Yes or Nerto Rican, etc.)	White, etc				
2 hours after "natural",	ক্র	3 Widowed 4 X D 15. Decedent's Education (Sp Elementary/Secondary (0-12		de completed)	16a. Deceder	Yes 2 X No t's Usual Occupationst of working life.	on (Give kind		Specify: U.	hite ss/Industry			
21215-0036 buld be filed within 72 hours af Mental Hygiene, marked other than "natural"	\sim 1	17. Father's Name (First, Middl	e, Last)		Act	countant 1			Account Maiden Surname)	ing			
y, MD 21215-0036 and 2 should be filed within lealth and Mental Hygiene, ten 27 is marked other that transmatic event, the Media	To Be	John Philip 19a. Informant's Name/Relation John P. Holla		r)				or Rural Route Nu	Delaney Route Number, City or Town, State, Zip Code) .utherville, MD 21160				
		20a. Method of Disposition 1 Burial 2 Crematic 4 Donation 5 Other	on 3 Removal f	20b rom State	. Place of Dispos crematory or ot	ition (Name of cen	netery,	Date D3/28/08	20c. Location - City				
Balt permit Depart Impor injury		21. Sgnature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility Ruck Towson Funeral 1050 York Rd., Towson, Maryland 236. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart											
Physician /Medical rexaminer		### Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):											
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus	b. Due to (or as a	a consequence									
be executed sician and urial - transit	al Examiner	(Disease or figury that initiated events resulting in death) Last	С.	a consequence	of):								
Sox 68760, leath certificate be exe at tending physician for use as the burial	in/Medical	UNPENDED IF FEMALE: 23b. Was decedent pregnant in		outcome of pre		tal death 3	Ectopic pre	egnancy	23d. Date of deli	very Day Year			
யு ் ∉் தி.	Physician/Me	past 12 months? 1 Yes 2 No 9 U Part II. Other significant cond	nknown g Unkn		death 5 Ot	her (Specify)	iven in Part I	23e Did	tobacco use contribut	e to the cause of death?			
cords, P.O. aw requires that the nas been signed by 2 should be detach			Mons contributing t				iveriii r ait i.		es 2 No 3 1	Probably 4 Unknown a autopsy findings available			
Division of Vital Records, as after death. al Director: After this certificate has been so an Director: After this certificate has been so they have the function, and the function has been so and the function has been so a should the function has been so a should have the function has been so a should have the function has been so a should have been	Completed by	25. Was case referred to medic	al I			26 Place	of Death (Che	1 Yes	ppsy prior formed? deat 2 ✓ No 1	to completion of cause of n? Yes 2 No			
of Vita ing Physician After this cer uneral direct	<u>8</u>	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatient	3 DOA	Other Nu	ursing Home 5	Residence 6 🗸 C	ther: Scene			
Sion of Attending Ph r death. ector: After t by the funeral	Certification:	2 Accident Inv	estigation Mar 26,); Day,Year)); 2008	FOUND: 1545 hrs	1 Y	y at Work? es 2 V No	Subject ha		Rural Route Number, City			
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide det	ermined (Specify)	Shed on	property	et, factory, office be		or Town, 553 Munroe		, MD			
To the Hos within 24 h To the Fun	[one) 2 Medical Ex	aminer:On the basis and manner:	of examination		tion, in my opinion,	death occurr		e and place, and due t	o the cause(s)			
		29b. Signature and title of certif	· This	Mill	us	29c. License O.C.N	00	OME	March 27, 200				
1241		36. Name and address of person Theodore M. King, Ji	., MD. Assista	ant Medical	Examiner	111 Penn Str	eet, Baltim	nore, MD 2120)1				
Sta Registr	~	31. Date filed (Month, Day, Year	1 2008 32.5	gistrar's Signa	ture for	We .							
DHMH 17 Rev 1/200)1				ORIGINA	L							

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MAZIE HUTCHINSON 10:10A M MARCH 30 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RANDALLSTOWN HOSPITAL BALTIMORE -NORTH WEST If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M **X** X F 84 Director 213-24-8156 Oct. 24,1923 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show must be notified at MD Baltimore 1 ☐ Yes 2 ☐ No Director Reisterstown the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Pages 1 and 2 should be filed within 72 hours after death with 230 Candytuft Rd. U.S.A. 23a 21136 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give 14. Race - American Indian, 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 □ Yes X2X No Baltimore, Maryland 21215-0036 ö Specify: Completed by X Widowed 4 □ Divorced Specify: ear or Dates: White 'natural' 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) r than " , the M Elementary/Secondary (0-12) College (1-4or 5+) 11 Nursing Assistant Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 Is marked or traumatic even Harry Beal ၉ Lucy Kidwell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 I Sharon Hutchinson/Daughter 230 Candytuft Rd. Reisterstown, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of I Important: If It any injury or o once. 1 ☐ Burial XXCremation 3 ☐ Removal from State Metro Crematory Inc. 4/2/08 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of for ral-Sprice Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. mun ance 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) VEMENTIA **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Universe or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical attending pl for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by ASCIRATION PNEUMONIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy perform 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Certification: To 21710 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After or Attending 1 Matural s after dea. ral Director: Aftr 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number MARCH 30 M.D. D57722 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1838 GREENE TREE ROAD #300 PIKESVILLE LEONARD RICHARDSON M.D.

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death ecedent's Name (First, Middle, Last) 3. Time of Death Month March ZZZOO **Physician** 1018AM a /Medical Facility Name (If not institution, give|street and number) vn, or Location of Death 4b. City. 4c. County of Death Examiner ttop Baltimore NS 105D 8. Date of/Birth (Month Day, Year) Jan 3, 1959 5. Social Security Number 7. Age If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Months unk 1 ☑ M 2 □ F Days Hours 49 170-50-4538 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director MD 1 X Yes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 203 S. Dallas Court 21231 USA Funeral death unk Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status e filed within 72 hours after d Il Hygiene. other than "natural", or item Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No black Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry un unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygie Important: If item 27 Is marked other any Injury or other traumatic event, tt once. 17. Father's Name (First, Middle, Last) Be (unk 18. Mother's Name (First, Middle, Maiden Surname) unk Pages 1 and 2 should be 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Johns Hopkins Hospital 600 N. Wolfe Street Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 □Removal from State 4 ☐ Donation 5 ★ Other (Specify) in state 21. Signature of Funeral S. N. R. D. a. I.d. 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIOPULMONARY ARREST MINUTES /Medical Due to (or as a consequence of) Examiner BLEEDING GASTROINTESTINAL Hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: ase 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes No
9 Unknown for Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à RENAL FAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No DIABETES MELLITUS 24a. Was an certificate has b autopsy perform ALLOHOLISM CHNONIC 2 **X**No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient ER/Outpatient Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) ို 1∰Yes 2□ No 3□ DOA this 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation Year 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier within 24 ho

To the Fune (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D66048 08

State Registrar N. WOLFE

STREET

BALTIMORE

21287

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MPH

600

32 Registrar's Signature

MO

			For State	State	of Marylan		artment o rtificate			Mental Hy	0	0000	10105	
ē			Registrar 1. Decedent's Name (First, Middle)	e, Last)		001	imoato	or bea		2. Date of De			3. Time of Death	
	ysicia Nedic	_	Margaret Cecel	ia Jacobs	3					March	27, Day	1:36 A.M		
	amin		4a. Facility Name (If not institution		umber)		4b. City, To			th	4c.			
- 2			4003 East-West		7 4 /	to a table to A	Chev:	y Chas	se nder 24 Hrs	0.51. (5:		ontgomer		
Fun Dire			5. Social Security Number 579–14–4581	6. Sex 1 □ M 2 🔀 F	7. Age (<i>In yr</i> s. 87	Yrs.		ays Hou		. (Month, D	av. Year)	Cor	nplace (State or Foreign Intry) nington, D.C	
land	er.		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation	-				10d. Inside City Limits		
Mary ⊢f sh e	fied a	to	Maryland Mont	gomery	Ch	evy Ch	ase						1 □Yes 2 No	
th the	e noti	Director	10e. Street and Number	,			10f. Zip Co	ode			10g. Citi	izen of What Cou	zen of What Country?	
ath will	nst b	ral	4003 East-West	Highway			2081.	5			Unit	ed State	es	
er deg	m Jer m	Funeral	11. Marital Status	Armed F		.S. 13.	Was Deceden f Yes, specify	t of Hispanio Cuban, Me	c Origin? (s xican, Pue	Specify Yes or Norto Rican, etc.)	0-	 Race - Amer Black, White 		
rs aft	xaHii	by F	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	ried 1 ∐ Yes If Yes, 0 Year or			1 □ Yes 2 □	No <i>Sp</i> e	cify:			Specify: W	hite	
2 hou	calE			t's Education		16a. Deced	dent's Usual C	ccupation			16b. Ki	ind of Business/l	ndustry	
# thin 7	Med	Completed	(Specify only highe Elementary/Secondary (0-12)		(1-4or 5+)	1	kind of work o							
ed wi	t, the	Co	12	1		Direc	tor of						Government	
Deficiency (Wally fallo Z Z 23-0030) permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show	tic even	To Be	17. Father's Name (<i>First, Middle,</i> Edward Brown	Last)					lother's Na Len Ti	_{me (First, Middle} ucker	e, Maiden	Surname)		
2 shou and I is ma	anma		19a. Informant's Name/Relations			1	-			Bural Route Numb				
and lealth	her tr	-	Deborah Ann Ja	cobs / Da					wу.,				nd 20815	
Pages 1 and 2 s nent of Health ar ant: If item 27 Is	or of		20a. Method of Disposition 1 Burial 2 Toremation			Place of Dispo cemetery, cren			1	Date		ocation - City or T		
nit. Partmer	injury		4 □ Donation 5 □ Other (S 21. Signature of Funeral Service		Mon					:11 3, 2008				
permit. Departn Importa	any		7.8.	<u> </u>	M0089	6 75	57 Wis	consi	n Ave	., Beth	esda,	sda-Chevy MD 208	Chase, Inc. 14-3501	
			23a. Part1. Enter the dis, ase, or shock, or h. vo failvre. List	complications that only one cause on	caused the deat each line.	h. Do not ent	er the mode o	f dying, suc	h as cardia	ac or respiratory	arrest,		Approximate Interval Between Onset and Death	
Physic /Medi	_		Immediate Cause (Final disease or condition resulting in death)		METAS		ccc	1201	U (ANCE	K			
Exami		П	,	Due to	o (or as a conseq	uence of):								
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to	o (or as a conseq	uence of):								
cuted	ransit	Examiner	Sequentially list conditions, if any, leading to immediate usua. Enter Underlying Cause (Disease or injury that initiated events	G.										
e exe	urial-t	Ĕ	resulting in death) Last	Due to	o (or as a conseq	uence of):								
icate be executed	the bi	dical		d										
Sertific ding p	se as	Me	IF FEMALE:	23c If yes o	utcome pf pregna	ancy					1			
atten atten	n Jor u	sician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐Live	birth 2 Feta	ıl death 3 □	Ectopic pregi				1	23d. Date of delive Month	very Day Year	
the d	ached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unk										
The law requires that the death certificate has been signed by the attending in	be det	by P	Part II. Other significant condition	ons contributing to	death but not res	ulting in the ur	nderlying caus	e given in P	art I.	23e. Did	tobacco ι	use contribute to	the cause of death?	
equire sen się	onid	ed								1 🗆	Yes 2	Maria 3 ☐ Pro	bably 4 □Unknown	
law r	N	Completed								24a. Was		24b. Were aut	topsy findings available ompletion of cause of	
sician: The law	director, page	S.								perf 1□ Yes	ormed? 2 ⊠ No	death? 1 ☐ Yes	2 9 No	
iclan certifi	ector	Be	25. Was case referred to medica examiner?	Hospital:				26. F	Place of De	ath (Check only	one)			
_ > .00 7	0	<u>۹</u>	1 ☐ Yes 2 ☑ No 27. Manner of Death		Inpatient 2 e of Injury	ER/Outpatien 28b. Time of		4L	Nursing	Home 5 Res 28d. Describe			sify)	
th.	e tune	ij	1 Natural 5 ☐ Pendin 2 ☐ Accident investig	g (Mo	onth, Day Year)	Injury	м	Injury at Work? 1 ∐ Yes	2 □ No	200. 20001120	now inju	y occurred		
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certifice	in by th	Certification:	3 Suicide 6 Could determ	ffice		28f. Location City or To	(Street an wn, State	nd Number or Ru	ral Route Number,					
pital	E		29a. Certifier 1 Certifyir	ig Physician: To th	ne hest of my kno	wiedne death	occurred at	ho timo da	to and plac	and due to the		and manner co	etated	
e Hos 24 hc e Fun	letely	Medical	(Check only 2 Medical one)	Examiner: On the	basis of examina nner stated.	tion and/or in	vestigation, in	my opinion	, death occ	curred at the time	, date and	d place, and due	to the cause(s)	
To the	comp	ğ	29b. Signature and title of certifie				29c. L	cense num	ber		29d. Da	te signed (Month	, Day, Year)	
,			· Com	Jano.	MA		1	005	7/2	-4	3	12710	OP	
カカ			30. Name and address of person	,			,	# • • •				0.50		
1 -1			Truong Bao, M.				r Dr.,	#201,	Rock	ville, N	4D 20	0850		
Re	Stat aistra		31. Date filed (Month, Day, Year)		Registrar's Sign	K La	and i							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 29, 2008 Year 8:45 AM Graham Archibald Jamieson 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Suburban Hospital Bethesda Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Months Days Hours 1X M 2□ F 14, 1929 New Zealand 78 064-32-4638 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5622 Johnson Avenue 20817 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 💢 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) American Red Cross $5\pm$ <u>Biochemist</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Andrew Wilson Ann Graham 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5622 Johnson Ave., Bethesda, MD 20817 Barbara M. Jamieson/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc. 20a. Method of Disposition March 31, 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 Bethesda, MD 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 755/Wisconsin Ave. Bethesda, MD 20814 21. Signature of Funeral Service Licenses 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardin 1cu te disease or condition resulting in death) Due to (or as a consequence of): vastro intestina Sequentially lie or uttors if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Coruna 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 2 No death? 1 □ Yes 2 □ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

Funeral

ð

Completed

Be

2

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic event."

attending physician and for use as the burial-trai signed t certificate has been si rector, page 2 should l funeral director, this

law requires that the death certificate be executed Physician/Medical Exam Completed by Be 2 Certification: within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Division or Vital Records, P.O. Box 68760,

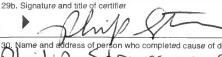
lamieson, Graham

State Registrar

Medical

29a. Certifier (Check only one)

31. Date filed (Month, Day, Year)



29c. License number

1 Fertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

D0044394

March 29, 2008

Name and address of person who completed cause of death (Item 23a) (Type, Print) MD

Suburban Hispital 8600 old Georgetown Rd, Bethesda, MD, 20814



Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2008 Morch LUb 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Mayland Matrollerter Baltinare (1) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Months | Davs | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 1**∑** M 2□ F Days Pennsylvania Director July 10, 1941 194-30-4391 66 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10a, State 10c. City. Town or Location 10d. Inside City Limits 10b. County ortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🔀 No Director Maryland Prince Georges Laurel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 13206 Clarington Ct. 20708 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: 2 White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Telecommunications Verizon 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Catherine Mullane John Joseph Luby, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13206 Clarington Ct., Laurel, MD 20708 Shirley Luby- wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory March 26, 2008 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fleck Funeral Home, INC. 7601 Sandy Spring Rd., Laurel, MD 20707 M0123 nn 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Aunetobacter MONT disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner month terated Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed burial-tran attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 4□Pregnant at time of death 9□Unknown in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the at d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an this certificate has page 2 autopsy performed2 2 No 1□ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific. completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28h Time of 27. Manner of Death 28d. Describe how injury occurred Certification: Injury at 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Lactifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S. Greene St. Soltimore DANICA NOVICIO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			for State Registrar	State of N	Marylan		artment o			and M		giene Reg. No.	/ 1111	8	10	183
		7	1. Decedent's Name (First, Middle, Las	t)			-				2. Date of De				3. Time of I	Death
	Physici /Medic		Glenn Aus	tin Lemo	n				1.0		March	20,	2008 ^{Yea}		10:25	P M
Ì	Examin	er	4a. Facility Name (If not institution, give	street and numbe	er)		4b. City, To	wn, or	Location o	f Death		4c.	County of De	eath		
		- 3	514 Monterey Aven		Age (In yrs. i	lant hirthday	Oder If Under 1		1 If Under 2	24 Hre	8. Date of Birt	da.	Anne A			E :
b	Funeral Director			X M 2□F	102	Yrs.		Days	Hours	Min.	(Month, Da) Dec 5,	y, Year)		Country)	e (State or ka	r Foreign
u žia	70		Usual Residence of Decedent		102						Dec 3,	1703	, 110	DIG	3 KG	
	show	Ļ.	10a. State 10b. County		10c. City	, Town or Lo	cation								Inside City 1 ☐ Yes	,
	he Ma 28a-f	Director	Maryland Anne Ar	unde1		0de	nton				1					2 (2)4110
	a or 2		10e. Street and Number				10f. Zip C					-	zen of What			
	eath	Funeral	514 Monterey Ave	12. Was Deceder	nt Ever in U.	S. 13. \	Vas Deceder		113	ain? (Spe	ecify Yes or No		nited 14. Race - Ar			
က	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces	s? XINo		_			, Puerto	ecify Yes or No- Rican, etc.)		Black, W			
9	ours a ral", c Exan	l by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	3:		I∐Yes 2Ž	No No	Specify:				Specify: V	hite	e	
5-0	72 h "natu dical	Completed	15. Decedent's Ed (Specify only highest grad			16a. Deced (Give	lent's Usual (kind of work of DO NOT use	Occupa done di	ition <i>uring most</i>	of worki	ng	16b. Ki	nd of Busines	ss/Indus	try	
12	within sne. than the Me	mp	Elementary/Secondary (0-12)	College (1-4o	or 5+)							Coon	a Host		c 44	20
d 2	Hygie Hygie ther	ပိ	8th 17. Father's Name (First, Middle, Last)			te	chnici		18. Mother	r's Name	(First, Middle,		s Heat	Ting	α AI	. I.
au	ld be ental ked o	To Be	Walter Lemo	n						ttie		ssey	,			
ary	shou and M s mar umat	٦	19a. Informant's Name/Relationship (7	ype. Print)		19b. Mailin	g Address (S	Street a	nd Numbe	er or Rura	al Route Numbe	er, City o	r Town, State	, Zip Co	ide)	
Σ	and 2 ealth a n 27 l		Cecil Lemon/son				ontere			e 0	denton,	Mar	yland	211	13	
ore	jes 1 of He if Iten		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐	Bemoval from Stat	20b. P	lace of Dispo emetery, crer	sition (Name natory or othe	of er place	e) :	D	ate	20c. Lo	cation - City	or Town,	State	
Ē	. Pag tment tant: jury c		4 □ Donation 5 □ Other (Specify)		t Arun							nton,		•	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparament of Health and Mental Hygiene. Information of the 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signar re of Funeral Service Licens	homas			Name and A Onalds 411 Ar	Address son nap	Funei Funei olis	ral l Roa	Home & d Oden	Crem	atory, Maryl	P. and	A. 2111	3
h			23a. Part Enter the disease, or composhock or heart failure. List only of	lications that clus ne cause on shoch	ed the death line.	n. Donot ente	er the mode of	of dying	g, such as	cardiac o	or respiratory ar	rest,		Int	proximate terval Betw nset and D	veen
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	MIV	Wh	OM,	4						Tw		ELKS
ď	/Medical Examiner		resulting in death)	Due to (or a	as a ponsequ	uende of):										-
) # E	-	Sequentially list conditions, if any, leading to immediate	b. — Due to (or ε	as a consequ	uence of):										
1.	uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	,	,											
9	exectan and rial-tra	Exa	resulting in death) Last	Due to (or a	as a consequ	ence of):									·	
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	dical		d												
8	ertifica ing ph e as t	Med	IF FEMALE:													
Вох	eath certific attending p for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐Live birth	2 🗌 Fetal	death 3	Ectopic preg					2	23d. Date of o Month	lelivery Da	v Y	ear
o.	ires that the de signed by the a I be detached I	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unknown		eath 5∟	Other (spec	ity)							,	
, Р. О	that the bed by detail		Part II. Other significant conditions co	ntributing to death	but not resu	alting in the ur	derlying caus	se give	n in Part I.		23e. Did to	obacco u	se contribute	to the c	ause of de	eath?
Records,	quires n sigr uld be	d by									1 🗆 \	es 2	≱ ₩0 3□	Probabl	y 4 □U	nknown
000	aw require s been sig 2 should b	Completed									24a, Was		24b. Were	autopsy	findings a	ıvailable
		mo	*								autop perfo 1⊟ Yes	rmed?	death	?	etion of ca ∃No	use of
Vital	slan; ertifica ctor, p	Be C	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o			25		
<u>~</u>	Physician; The la	10	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpa		ER/Outpatien		Other	4 🗆 Nui	rsing Hor	ne 5 Resid	lence 6	6 □Other (S	oecify)		
Division or	ding F h. After funera	iuo]	27. Manner of Death 1 → Matural 5 ☐ Pending	28a. Date of In (Month, E		28b. Time of Injury		. Injury Work			28d. Describe h	now injur	y occurred			
<u>S</u>	l or Attend after death Director; I in by the f	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of in	niun, - At ho	me farm etre	M		es 2□N	-	196 Location /6	Person on	d Number or	Dural D	n i den Ali imali	ha.r
<u>></u>	after Direction by	Certification:	4 ☐ Homicide determined	building,	etc. (Specify	()	et, factory, o	ilice		-	28f. Location (S City or Tow			nurai ni	oute Numi	oer,
	To the Hospital or Attending Physiclan; within 24 hours after death. To the Funeral Director; After this certifics completely filled in by the funeral director; p	Medical C	29a. Certifier (Check only one) 1 1 Triffying Phy 2 Medical Exam	iner: On the basis	of examinat	wledge, death tion and/or inv	occurred at restigation, in	the time	e, date and inion, deat	d place, a th occurr	and due to the ed at the time,	cause(s) date and	and manner I place, and c	as state	d. e cause(s)	
	o the o the omple	Mec	29b. Signature and title of certifier	and manner	stated.		29c. L	icense	number		1	29d. Dat	e signed (Ma	nth. Dav	v. Year)	
	- S - Ö			\u		1.2		7	· ()	77			_ ^	-		15
		1	30. Name and address of person who c	ompleted cause of	death (Item	23a) (Type. I	Print)		. 2 .		(7)	· (u				0
	19		MICHAEL FR	889W	AN	116	Defer	se	tha	hwa	4 Ar	Na	ocis	MI	0 2	1401
\$	Sta	-	31. Date filed (Month, Day, Year) MAR 3 1 201	32 Regis	strar's Signat	ture	DB.)	, , , , ,	1		1			
	Registra	ar	MAL 9 I ZO	Jan Day	The second	" SOM	ME									

			1 - For State Registrar	State of Ma	arylan				lealth a D <i>eath</i>	and Me		jiene leg. No.	008	10189
	Physici		1. Decedent's Name (First, Middle, Last)			Lo	za				2. Date of Dea Month March	th Day	Year 2008	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give st					_	Location o				unty of Dear	h
	Funeral Director		Johns Hopkins Hos 5. Social Security Number 6. Sex 548-75-0761		e (In yrs.	last birthday) Yrs.		altin or 1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day Aug. 7	Year) 1969	9. Birt	hplace (State or Foreign untry)
	ס		Usual Residence of Decedent 10a. State 10b. County			y, Town or Lo	cation				Aug. 7	, 190	Cal	10d. Inside City Limits
	deeth with the Maryland Ims 23a or 28a-f show Findst be notified at	Director	Maryland Harford 10e. Street and Number			Bel Ai:		p Code			· · · · · · · · · · · · · · · · · · ·	10a. Citizer	of What Co	1 ☐ Yes 2 🕅 No
	s 23a or		2205 Byrnes Court	Apt. J				21	.015				J.S.A.	
DESILITIOTE, INSTITUTE A LATE 19-0050 permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or items 23a or 28a-1 show way injury or other treumatic avent, the Medical Examiner must be notified at once.		by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Armed Forces? 1 ☐ Yes 2 XI If Yes, Give Year or Dates:		If Yes, specify Cuban, Mexican, Puerto Ridan, etc.) Black, White,						nican Indian, e, etc. exican		
0-617	vithin 72 ho ne. hen "netur e Medicel	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0·12)	Completed) College (1-4or 5	5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Busin								
7	e filed wall Hygier other the	Be Cor	17. Father's Name (First, Middle, Last)	4 years		Manag	emer	it Pro			.yst (First, Middle,	Maiden Su	F.B.	[.
yla	should b	To	Leobardo Vasquez			19b. Mailin	g Addre	s (Street a			Stella Route Numbe			
Z, MG	and 2 sealth ar m 27 is		Marsha Louise Loza		ife)	4519	Brid	gest		oint	Drive	Spri	ng, Te	exas 77388
allullore	Pages 1 lent of H nt: if its ry or oti		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	C	lace of Disposemetery, cremetery	atory or	other plac	1	3-31	-08		ion - City or	Maryland
	permit. Departm Importa eny inju		21. Signature of Funeral Service Licenses			22	Alama	and Addrson	a of Facility					1.21215
	Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ACUTE Due to (or as	ne.	n. Do not ente	er the mo	de of dying	g, such as o				Lyland	Approximate Interval Between Onset and Death HMONTHS
K	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	uence of):										
, ,00,0	cate be executed physicien and the buriat-transit	dical Exa	Tesulting in death) Last Due to (or as a consequence of):											
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours elfer death. To the Funeris elfer death. To the Funeris Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1									23d. Date of delivery Month Day		
, L	quires that t n signed by uld be deta	Ď	Part II. Other significant conditions conti	ributing to death b	ut not res	ulting in the un	derlying	cause give	en in Part I.		23e. Did to			the cause of death?
חמנים	The law resete has bee page 2 sho	Completed						<u> </u>		_	24a. Was a autop perfor 1 Yes	sy	4b. Were at prior to death?	utopsy findings available completion of cause of
A 160	/siclan: s certific director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	spital: 1 XInpatie	nt 2 🗆	ER/Outpatient	3 🗆 🗆	OA Othe	200		(Check only or e 5 ☐ Resid		Other (Sne	cifu)
5	To the Hospital or Attending Physician: The within 24 hours effer death. To the Funeral Director: Affer this certificete he completely filled in by the funeral director, page	ation; T	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da		28b. Time of Injury	м	28c. Injury Work		28	Bd. Describe h			50,77
	To the Hospital or Attandi within 24 hours effer death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc.	ury - At ho c. (Specif)	ome, farm, stre	et, facto	ry, office		21	Bf. Location (S City or Tow		umber or Ri	ural Route Number,
	a Hospi 24 hou Funari letely fill	edicai	29a. Certifier (Check only one) Certifying Physical Examine	cian: To the best or: On the basis of and manner sta	examina	wledge, death tion and/or inv	occurre estigation	dat the tim n, in my op	e, date and pinion, deat	d place, ar h occurre	nd due to the o	ause(s) and late and pla	d manner as ace, and due	s stated. to the cause(s)
	Yoth Yoth comp	Me	29b. Signature and title of certifier	, Medica	OLD	octor	2	c. License)			igned (Mont	h, Day, Year)
	25						Print)		2878					
	Sta	te	Nina Wagner Thes 31. Date filed (Month, Day, Year)	ohns Hopk	cins l	tospital	600	Nort	n Wol	te Sh	reet B	altimo	re, M	0 21287
	Registr		MAR 3 1 2008	Man se	, B	lure	2							

DHMH 17 Rev 1/2001

Joseph Lineberger	State of Maryland / Department of Health and Mental Hygiene amend #1 Per ME G877 Certificate of Death Reg. No.) 9
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year 1746 hrs	
	JOSEPH LOUIS LINEBERGER JR. March 14, 2008 4a. Facility Name (if not institution, give street and number) Northbound Georgia Avenue at Gregg Road Ab. City, Town, or Location of Death Sunshine Montgomery	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State of Months Days Hours Min. 8-6-1989 Country) M.	
v any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside Ci	
the Maryland or 28a-f show any lifted at once.	MD N/A Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	X
r death with the or items 23a or must be notific Funeral Di	9208 Oswaldway 21237 U S A 11. Marrital Status 1 X Never Married 2 Married 2 Married 2 Married 2 Married 1 Married 1 Married 2 Married 2 Married 2 Married 2 Married 2 Married 2 Married 2 Married 1 Married 2 Married 2 Married 2 Married 2 Married 2 Married 2 Married 8 Married 8 Married 1 Married 1 Married 1 Married 2 Married 8 Married 8 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 2 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 2 Married 1 Married 2 Married 1 Married 1 Married 1 Married 1 Married 1 Married 1 Married 2 Married 1 Married	ick,
s after deat ural", or ite	Wildowed 4 Divorced If Yes, Give Year or Datack 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done) 16b. Kind of Business/Industry	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade College College College Never worked	N/A
Baltimore, MD 21215-0036 oermit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygene. Important: If item 27 is marked other than mjury or other traumatic event, the Medica To Be Complé	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph L. Lineberger, Sr Regina V. Warren	
MD 21 nd 2 should alth and Me m 27 is ma aumatic ev	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Regina V. Warren-Mother 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State)	
imore, Pages lar ment of Hec iant: If ite or other tr	1 X Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Crematory or other place) Arbutus Memorial 3-21-2008 Arbutus, MD	
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H East 1101 E. North Avenue Balto, MD 2120 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Approximate	02 e Interval
Physician M. dical Examiner	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	nset and
ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
executed an and al-transit ical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.	
60, ate be executed hysician and e burial - transit	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery	
D. Box 68760, the death certificate be by the attending physicicle ched for use as the burn Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown	Year
P.O. B s that the d gned by the e detached i by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death but not resulting in the underlying cause given in Part I.	death? Jnknown
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buriledical Certification: To Be Completed by Physician/Med	24a. Was an autopsy findings autopsy prior to completion of completion	
Vital Re ysician: The certifical director, pa	25. Was case referred to medical examiner? Hospital: 4 Inpution: 2 EP/Output at 1 DOA Other Nursing Home 5 Residence 6 ✓ Other: Scene	
on of \ ending Phy ath. r: After th the funeral	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month Day Year) Mar 14, 2008 28b. Time of Injury 1730 hrs 28c. Injury at Work? 1 Yes 2 ✓ No 28d. Describe how injury occurred Driver auto auto collision	
Division of Vital Division of Vital Division: To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director. edical Certification: To Be (2 Accident Investigation 3 Suicide 6 Could not be determined Company Major Road / Highway 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Numb	
To the Hospital within 24 hours To the Funeral completely fille	29a. Certifier (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
≥	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, O.C.M.E. March 15, 2008)
12	30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State Registrar	MAR 3 1 2008 From M. Garle	
DHMH 17 Rev 1/2001	ORIGINAL	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-02162 State of Maryland / Department of Health and Mental Hygiene Russell Myers Lockett, 3rd Certificate of Death Reg. No Registrar

1. Decedent's Name (First, Middle,Last) Date of Death Physician/ Month Day March 17, 2008 0815 hrs Med:িবI Examiner Russell Myers Lockett III 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore University Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min CountryMaryland Director June 25, 1954 53 217-50-9157 1 XM 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 1 Yes 2 No "natural", or items 23a or 28a-f show Examiner must be notified at once. Anne Arundel Annapolis MD Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number USA 21401 80 West Street 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or items Armed Forces' 1 Never Married 2 Married 2 X No Yes Yes 2 X No specify: Specify white 4 X Divorced If Yes, Give Year Widowed ģ 16a. Decedent's Usual Occupation (Give kind of work done unk 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 hours pleted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical Baltimore, MD 21215-0036 building trades unk other 18. Mother's Name (First, Middle, Maiden Surname) t. Pages I and 2 should be filed wittment of Health and Mental Hygier rant: If item 27 is marked other 17. Father's Name (First, Middle, Last) Marie Van Hoy Russell Myers Lockett event, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3807 N. Garden Avenue Roswell, NM 88201 Marie Lockett/mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 Cremation 3 Removal from State Donation 5 X Other Specify 22. Name and Address of Facility 21 Si ture of n Service State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Director Approximate Interval Treations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Part I. Ent the discase, or **Physician** Between Onset and failure. List only one cause on each line. Death Medical Pneumonia com licated by blunt force chest injuries Immediate Cause (Final disease .aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical X UNPENDED AMENDED 23a, 27, 28a-f per ME g878 4/9/08 amh attending physician or use as the burial -23d. Date of delivery Box 68760 23c. If yes, outcome of pregnancy Year 3 Ectopic pregnancy 23b. Was decedent pregnant in the Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown ð Completed 24b. Were autopsy findings available 24a. Was an certificate has been ector, page 2 should prior to completion of cause of autopsy performed? death? 1 🗸 Yes ✓ Yes 2 No 2 No 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be Other₄ examiner? Hospital: 1 / Inpatient 2 Nursing Home 5 Residence 6 DOA ER/Outpatient 3 this 1 V Yes 28d. Describe how injury occurred 28c. Injury at Work 28b. Time of Injury After 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Natural Yes 2 X No 5 Pending Director: d in by the f hours after death. 3/14/08 8:00pm Subject assaulted 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 Could not be or Town, State) Suicide (Specify)Street determined 80 West St Appapolis MD 4 X Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 18, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Patricia Aronica-Pollak MD. 32. Registrar's Signatu 31. Date filed (Month, Day, Year) State 2008 MAR 3 Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Charles David 37 200B 10:20 PM Mavan M095 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Washington Hagerstown Washington County Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 6. Sex 12 M 2 ☐ F 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months 214-34-0014 Director AUGUST 4, 1937 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 1 □Yes 2X No Director Washington Hagerstown Mary land 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Boulevard 21740 20409 Kings Crest USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Agent Purchasing chasing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wilmer D. Moss Margaret Vo Ditmer ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Date | 200: Location - City or Town, State Selena Luther 13401 Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State March 29,2008 4 Donation 5 ☐ Other (Specify) Anatomy Gifts Registry Hanover, 21. Signature of Funeral Service Licenses Anatomy Gifts Registry 17522 Connelley Drive Suite P. Hanover, MB 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ter25 UMUNAM /Medical ue to (or as a conse pence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): sician and burial-transit Due to (or as a consequence of): physician a P.O. Box 68760. Physician/Medical SBS attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown þ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has performed? Yes 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes ၉ 2**□**No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation the Hospital or Attending Injury 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (SpecIfy) filled in by 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Physician 30. Name and address of narson who completed cause of death (Item 23a) (Type, Print) Jeffrey +
31. Date filed (Month, Day, Haserstown, MD 21742 11110 Medical Campus STE130 Hurwitz Year) 32. Registrar's Signature State Registrar 2008

DHMH 17 Rev 1/2001

	·	9	
or	State of Maryland / Department of Health and Mental I	Hygiene 2 1 1 8	
ate egistrar	Certificate of Death	Reg. No.	

- 4	9
Physi	ician
/Med	dical
Exam	niner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at annex.

Baltimore, Maryland 21215-0036 Physician /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760, 10 Sta Registrar DHMH 17 Rev 1/2001

	Registrar				Cel	uncate o	Dec	<i>a</i> 111		Reg. N	lo.			
	1. Decedent's Name (First, Middle, La	st)						2. Date of D			.,	3.	Time of Death
an	John	Allen	Peter M	ierzeck	ำ				Month March		200	Year Q		9:02 P M
cal 1er	4a. Facility Name (If n					4b. City, Town	or Loca	ation of Death			c. County			J. UZ I
IC1					ľ									- 1
	723 Linder 5. Social Security Nun			ge (In yrs. last.	hirthday)	If Under 1 Yea	nton	Inder 24 Hrs.	8. Date of Bi	rth	Ann	e Ar		
	, ,		X M 2□F	. ,	Yrs.	Months Day		ours Min.	(Month, D	ay, Yea				(State or Foreign
	579-62-565 Usual Residence of D			56					May 18	5, L	951	wash	ııngı	ton, DC
		Ob. County		10c. City, To	wn or Loc	cation							10d In	nside City Limits
-	Tour ordin	ob. County												□Yes 2 No
ctc	Maryland	Anne Ar	undel		Ode:	nton							'	
Jire	10e. Street and Numb	er				10f. Zip Code				10g. (Citizen of 1	What Co	ountry?	
= =	723 Linder	Grove	Place #2	03		21	113				IIni	ted	Stat	tes
Jer	11. Marital Status		12. Was Decedent	t Ever in U.S.	13. V	Vas Decedent of f Yes, specify Co		ic Origin? (Sp	pecify Yes or N	0-		e - Ame		
Fur	1 ☐ Never Married	Married	Armed Forces' 1 ☐ Yes 2 📉		1	f Yes, specify Cu	ıban, Me	exican, Puerto	o Rican, etc.)		Bla	ck, Whit	e, etc.	
5	3 ☐ Widowed 4		If Yes, Give Year or Dates:		1	□Yes 2 X N	o Sp	ecify:			Specif	v: LTh	ite	
- D	1	5. Decedent's Ed	ducation	16	Sa Deced	lent's Usual Occ	unation	_		16b	Kind of B			,
et		only highest gra			(Give I	kind of work dor OO NOT use reti	e during	g most of worl	king	1			•	
盲	Elementary/Second	lary (0-12)	College (1-4or							Dе	-		oi	Treasury
Be Completed by Funeral Director	47 5 H 1 N 45		. 4		Comp	uter Spe			(F)			IRS_		
Be	17. Father's Name (Fi	irst, Middle, Last,	,				18.1	Mothers Nam	ne (First, Middle	, Maia	en Surnar	ne)		
မ	Edward	Mierze	eski					Louis	e_D.	Laz	evnic	k		
	19a. Informant's Nam	e/Relationship (Type. Print)	1	9b. Mailin	g Address (Stre	et and N	lumber or Ru	ral Route Numi	er, City	or Town,	State, 2	Zip Code	e)
	Linda C.	Mierzesl	ki/wife		984 I	all Cir	c1e	Way	Gambri1	1s,	Mary	lan	d 21	054
-	20a. Method of Dispos			20b. Place	of Dispos	sition (Name of			Date	20c.	Location -	City or	Town, S	State
			Removal from State	9		natory or other p	,	0.40		_		•		_
	4 □ Donation 5			West		lel Crem				l .	entor	-	_	
	21. Signature of Fune	eral Service Lice	reee		Dc	Name and Add	ress of l	^{Facility} neral l	Home &	Cre	mator	v.	Р.А.	
	tuanit	to KY	homas		14	11 Anna	pol:	is Roa	d Oden	ton	, Mar	ýĺa:	nd 2	1113
	23a. Part \ Enter the	disease, or com		d the death. D	o not ente	er the mode of d	ying, su	ch as cardiac	or respiratory	arrest,			App	roximate rval Between
	Immediate Cause (Fir												Ons	et and Death
	disease or condition resulting in death)		и.	cic Fai										
	,,		Due to (or as	s a consequenc	e of):									
Sequentially list conditions b. Metastatic Luny Cancer														
ne	Sequentially list condi- it any leading to immo cause. Enter Underly	ediate	Due to (or as	s a consequenc	e of)c							- 1		
Ē	cause. Enter Underly Cause (Disease or injustrat initiated events	ury	c Color	n Cance:	r									
X	resulting in death) Las	st	Due to (or as	a consequenc	e of):									
- a			d											
Completed by Physician/Medical Examiner														
Ě	IF FEMALE:		23c. If yes, outcome	e of pregnancy							00-1 D-	A6 -1-1		
iar	23b. Was decedent p		1 ☐Live birth	2 ☐ Fetal dea		Ectopic pregnar	тсу				23d. Da Mo	nth	Day	Year
sic	1 ☐ Yes 2 ☐ N 9 ☐ Unknown	No	4⊟Pregnant a 9⊟Unknown	at time of death	5	Other (specify)							,	
Phy														
5	Part II. Other significa		-				given in I	Part I.	23e. Did	tobacc	o use con	tribute to	the cau	use of death?
b	Chronic	obstru	ctive puln	nonary (disea	ase			1 🔀	Yes	2	3 □ Pi	robably	4 ∐Unknown
et									24a. Was	an	24h	Were a	itonev fi	ndings available
윤									auto			prior to death?	complet	ion of cause of
ပိ									1□ Yes			1 ☐ Yes	2 🗆	No
Be	25. Was case referred examiner?	d to medical	* 1i* *			γ		Place of Dea	th (Check only	one)				
ဥ	1 ☐ Yes 2 🛣 No	•	Hospital: 1 ☐ Inpati	ient 2 ER/0	Outpatient	t 3□ DOA C	ther: 4	☐ Nursing H	ome 5 🔀 Res	idence	6 □Oth	er (Spe	cify)	
ä	27. Manner of Death		28a. Date of Inj (Month, Da	ury 28t	. Time of Injury	28c. In	ury at		28d. Describe	how in	jury occur	red		
£	1 X Natural 2 ☐ Accident	5 Pending investigation	, ,	ay rear/	Hijary			2□No						
fice	3 ☐ Suicide	6 Could not be	Zoe. Place of III	jury - At home,	farm, stre	et, factory, offic	е		28f. Location	Street	and Numl	er or R	ural Rou	ite Number.
Ħ	4 ☐ Homicide	determined	building, e	tc. (Specify)	ŕ				City or To	wn, Sta	ate)			,
ŭ	00-0-46 41	M 0	To the last					1						
Medical Certification:	(Check only 2	☑ Certifying Pri ☐ Medical Exar	nysician: To the best niner: On the basis	t of my knowled of examination	ige, death and/or inv	occurred at the restigation, in m	time, da y opinior	ate and place n, death occu	, and due to the rred at the time	cause , date a	(s) and m and place,	anner as and due	s stated. e to the	cause(s)
led	one)		and manner s	tated.										
2	29b. Signature and titl	le of certifier	1			29c. Lice	nse num	nber		29d. [Date signe	d (Mont	th, Day,	Year)
	V	2 SUL	la Aron h	10		D2	843	6			Marc	h 2	4. 2	2008
	30. Name and address	s of person who	completed cause of	death (Item 23s) (Type F									
								C., - + -	1 0	£ + -	n M-	. 245 - 7	and	2111/
	Nellle 31. Date filed (Month,		aker, M.D.	rar's Signature	CLOIL	on cent	er,	Sulte	I, UTO	T CO.	u, Ma	ттут	and	41114
te		-	200	_										
ar	1817	111 0 1 41	JUB JUB	s. M	S. Section	W.								
					20 1									

				Please				Indelible Ink		-		•		
			For State Registrar		State of N	/larylan		epartment of F Certificate of		lental Hy	/giene Reg. No	0000	10101	
	50.		Decedent's Name	e (First, Middle, L	.ast)					2. Date of D	eath		3. Time of Death	
	Physicia Medic/			Catherine		Mayer				March	March 26 2008 6:00			
,	Examin	er			ive street and numbe	r)			or Location of Death			County of Deat		
F	uneral	Ģ.	5. Social Security N	Maris	Sex 7	Age (In yrs.	last birtho	Timoniu	If Under 24 Hrs.					
	irector		220-07-08		1 □ M 2 💢 F	89	Yrs	Months Days	Hours Min.	Nov.			ryland	
land	ow ut		Usual Residence of 10a. State	10b. County		10c. Cit	y, Town o	r Location					10d. Inside City Limits	
Mary Mary	a-f sh	ctor	Md.	Baltin	nore	Lu	therv	ille					1 □Yes 2 □ No	
5-UU36 72 hours after death with the Maryland	item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Director	10e. Street and Nur					10f. Zip Code	1.000		10g. Cit	izen of What Co	-	
leath v	ns 23g must	Funeral	151 /	Bellona	AVE.	nt Ever in U.	21093 ver in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No					US 14. Race - Ame		
after d	or Iten miner			ied 2□ Married	Armed Force	s?	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					Black, White, etc.		
5-0036 72 hours aft	ural", al Exar	d by	3 X Widowed		Year or Dates	s:	10- D				40h 10	Specify:	White	
. 13	n "nat Aedica	Completed	(Spec	15. Decedent's cify only highest g	rade completed)	~ F.\	loa. De li	ecedent's Usual Occup Rive kind of work done fe. DO NOT use retire	pation during most of work ed)	ing	16b. K	ind of Business/	Industry	
a Kiled within 7 al Hygiene.	er tha	Com	12		College (1-4d	1 J+)	Но	memaker	T			Own Home		
and Id be file ental Hy	event	Be	17. Father's Name		st) Demmitt				18. Mother's Name	e (First, Middle Viola		surname) eenwood		
Maryland 2 should be f 1 and Mental I	marke	မ	19a. Informant's Na				19b. M	ailing Address (Street	Lula Land Number or Rui				Zin Code)	
ore, Ma ss 1 and 2 si of Health an	27 Is er trau			·	e/ Daughte	r	Ī	517 Bellon			-		•	
ore, jes 1 g t of He	Important: If item 2 any injury or other once.		20a. Method of Disp		☐Removal from Sta	20b. F	Place of Di cemetery,	sposition (Name of crematory or other pla	ice)	Date	20c. L	ocation - City or	Town, State	
baltimor bermit. Pages Department of	rtant: njury c			5 ☐ Other (Spec	cify)		relan	d Memorial	Park 3-2	9-08	Pa	rkville	, Md.	
balt permit. Departn	any ir		21. Signature of Fu	ineral Service Lic	ense	X		22. Name and Addre	wson Fune ork Rd. To	ral Hon	ne, I	nc.		
			23a. Part1. Enter the	he disease, or co	mplications that caus	ed the deat	h. Do not	enter the mode of dyi				1204	Approximate Interval Between	
	sician		Immediate Cause (Final	a a	30	26	novesa	430	1150	1-> 5	- 9	Onset and Death	
	edical miner		resulting in death)		Due to (or a	as a conteo	(nce of):	reschy	63/2					
380	. A.	er	Sequentially list concause. Enter Under Cause (Disease or	nditions,	b. — Dan to (or o	as a conseq	uerne si):							
executed (X	nd transit	Examiner	that initiated events		c									
be ex	ician a burial	_	resulting in death) L	asi	Due to (or a	as a conseq	uence of):							
The law requires that the death certificate be	physisthe as the	Physician/Medica			d									
ath cert	ending r use	an/M	IF FEMALE: 23b. Was deceden		23c. If yes, outcor			3 ☐ Ectopic pregnanc	ev.			23d. Date of deli		
be dea	the atf	/sici	in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	No	4□Pregnant 9□Unknown	at time of d		5 ☐ Other (specify) _	·			Month	Day Year	
that t	ed by		Part II. Other anii	i t conditions		but not res	ulting in th	e underlying cause giv	ven in Part I.	23e. Did	tobacco	use contribute to	the cause of death?	
ecords, law requires t	en sigr	ed by		- 2-01	72					1 🗆	Yes 2	□No 3□Pr	obably 4 Unknown	
law re	as be	Completed								24a. Was	opsv	prior to o	topsy findings available completion of cause of	
lian: The	icate h										formed? 2 A No	death? 1 ☐ Yes	2 🗆 No	
VIII	s certif	To Be	25. Was case refer examiner? 1 ☐ Yes 2 ☑		Hospital:	tient 2□	ER/Outpa	tient 3 DOA Oth	26. Place of Deat			6 □Other (Spec	cifu)	
ding Ph	fter thi		27. Manner of Deat		28a. Date of I		28b. Tim Inju	e of 28c. Inju		28d. Describe			cny,	
ttendi death.	tor: A	icatic	2 ☐ Accident 3 ☐ Suicide	investigati 6 ☐ Could not	be gen Place of	niunz - At ho	ome form	M 1 □ , street, factory, office]Yes 2□No	29f Looption	(Stroot o	nd Number or Pr	umi Pouto Number	
after of	l Direct	Certification:	4 ☐ Homicide	determine	d building,	etc. (Specif	y)	, street, factory, office		City or To			ural Route Number,	
DIVISION OF VII.d. To the Hospital or Attending Physician: within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier (Check only	1 ← ertifying F	Physician: To the be	st of my kno	wledge, d	eath occurred at the to or investigation, in my	ime, date and place,	and due to the	e cause(s	and manner as	s stated.	
thin 24	mplet	Medical	one) 29b. Signature and	_///	and manner			29c. Licens		Tod de tillo tille		ate signed (Monta		
, ×	₽ 8	-	b dignature and	1/30	fold &		200	9	1550	5		3 - 2	2.08	
	5		30. Name and addr	ess of person wh	o completed cause o	f death (Item	n 23a) (Ty	pe, Print)						
	J		EDDIE 31. Date filed (Mon	NAKHUDA		2. strar's Signa		DULANEY VAI	LLEY ROAD		TIMO	NIUM MI	21093	
	Sta Registr		M.L.		008			raile)						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician 1:51PM M March 26, 2008 Sergius Harry Mamay /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1**X** M 2□ F Director 269-12-7447 May 20, 1920 Ohio Usual Residence of Decedent 10c. City, Town or Location 10a State 10h Counts 10d. Inside City Limits 28a-f show ıral", or items 23a or 28a-f shov I Exaπiner must be notifled at 1 ☐ Yes 2 ☑ No Director Montgomery Maryland Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural", or items 23a 8001 Carita Court 20817 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give Year or Dates: WWII Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No ģ Specify: 3 Widowed 4 Divorced WWII White Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Paleobotanist Researcher U.S. Geological Survey 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Gregory Mamay Elizabeth Skirpan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra 7631 Apple Tree Circle Orlando, Florida 32819 Patricia M. Conklin/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium Inc. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State March 28, 2008 4 Donation 5 Dother (Specify) Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase. Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licensee M00335 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List enty one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Coronary Atherosclerosis /Medical Due to (or as a consequence of): Examiner Cardiac Arrest Sequentially list conditions, if any to any to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Pneumonia Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown as been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Congestive Heart Failure 24a. Was an has autopsy page perform certificate Hypertension 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ D**O**A after death.

I Director: After this of in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 🕅 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 1 ី Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Division or Vital Records, Hospital or Attending Physician: Mamay within 24 hours aft

To the Funeral Di

completely filled in within 2

within 72 hours after

Pages 1 and 2 should be

Baltimore, Maryland 21215-0036

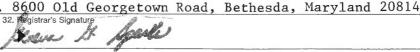
3/26/08

Serglus

Box 68760.

Ö

Steven D. Wilks, M.D. 31. Date filed (Month, Day, Year) State Registrar MAR 3



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



D0006395

March 27, 2008

State of Maryland / Department of Health and Mental Hygiene 1- State Registraamend #10e Per FH G878 4/07/@PerJulicate of Death 2. Date of Death Day **Physician** Genevieve E. Mansfield 29, 2008 March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛚 F Months Days Hours Min. Director 579-36-6200 96 Dec. 28, 1911 Michigan Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10b. County r 28a-f sh notified Director Maryland Montgomery Silver Spring 3503 Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 305 S. Leisure World Blvd. #C-1 20906 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White þ 3 X Widowed 4 □ Divorced Year or Dates: 'natural' Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Montgomery County College (1-4or 5+) Elementary/Secondary (0-12) Public Schools Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fil tment of Health and Mental H tant: If item 27 Is marked out jury or other traumatic even Be William Zann Bernice Tadajewski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Raymond J. Mansfield/Son 4821 Sundown Rd., Laytonsville, MD 20882 20b. Place of Disposition (Name of cemetery, crematory or other place Parklawn Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State April 2, 1 XBurial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any Injury or 4 □ Donation 5 □ Other (Specify) 2008 Rockville, MD 22 Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Ave. Rockville, MD 20850 21. Signature of Funeral Service Licensee M01346 Rockville, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive Heart Failure /Medical Due to (or as a consequence of): Examiner Acute Myocardial Infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 No Month 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 ☐ Unknow signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Stroke, Pneumonia, Fecal Impaction, Completed Hypernatremia certificate has birector, page 2 s autopsy performed 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes 2 No 1 → Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: To funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 1 ☐ Yes 2 ☐ No

Approximate Interval Between Onset and Death 11 Days 11 Days 23d. Date of delivery Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 5 ☐ Pending investigation 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D53654 march 29,2008 30. Name and a Medical Center Drive, Mourine, uno 20850 S Gol. Registrar's Signature 140 31. Date filed (Month, Day, Year) 2008 1 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

7:00

10d. Inside City Limits

1 ☐ Yes 2 No

A

2

Medical

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Eugene J. Miller 26, 2008 10:50 PM March 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 14190 Travillah Road Montgomery Rockville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) October 13, 1958 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign Months Days Hours Min 49 Washington, D.C. 216-64-0719 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 □XYes 2 □ No Maryland | Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14190 Travillah Road 20850 United States Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner Landscape 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anthony G. Miller, Jr. Mary Catherine Prosise 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cameron Parke Place, Alexandria, Virginia 22304 Colleen M. Miller / Sister 20c. Location - City or Town, State Silver Spring, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) April 1, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 4 □ Donation 5 □ Other (Specify) 2008 Maryland 21. Signature of Fungal Service Licenses Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 Approximate Interval Between Onset and Death 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) hepatocellular cancer Due to (of as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of) If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 1 Yes 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

ıral", or items 23a or 28a-f show I Examiner must be notified at

'natural", or

Director

Funeral

ģ

Completed

Be

ပ

Examine

Physician/Medical

by

Completed

Be

٩

Certification:

Medical

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or ite

injury or other traumatic event,

permit. Pages 1 and 2 s Department of Health ar Important; if Item 27 Is any injury or other trau once.

Baltimore, Maryland 21215-0036

and attending physician for use as the hirial certificate

this After t

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after
To the Funeral Dir

Division or Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, a ling to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. Was an 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ome 5 Residence 6 Other (Specify)
28d Describe how injury occurred 1 ☐ Yes 27. Manner Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated.

29c. License number

MD

29d. Date signed (Month, Day, Year)

MI

153070

Daniel Alexander Laheru, M.D.

March 27, 2007

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) St Balhmore,

31. Date filed (Month, Day, Year) State



Registrar

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Q 1

Division or Vital Records, P.O. Box 68760-

		Please	Type or Print in I				_	_	
		For State Registrar	State of Marylar	nd / Departm <i>Certific</i>			, 0	2000	000
±g ⁴	7	Registrar Decedent's Name (First, Middle, La	st)	Oertino	ale of	Death	Reg. 2. Date of Death		3. Time of Death
Physici /Medic		Paul Leroy	Mc Cardell	î 			March :	Le 2008	2:35 AM
Examir		4a. Facility Name (If not institution, giv	e street and number)	4b. 0	City, Town, o	or Location of Death		4c. County of Dea	ith
Funeral		5. Social Security Number 6. S	Sex / 7. Age (In yrs.		nder 1 Year		8. Date of Birth	Cecil 9. Bio	rthplace (State or Foreign
Director		217-22-0952	10	O Yrs. Mon	ths Days	Hours Min.	(Month, Day, Ye	927	ountry) MD
land ow rt		Usual Residence of Decedent 10a, State 10b. County	10c. Ci	ty, Town or Location					10d. Inside City Limits
Marylan a-f show iffed at	ctor	MD Balti	more.	Edgemer	مص				1 ☐Yes 2 ☐ No
be filed within 72 hours after death with the Maryland the Hygiene. In the Hygiene. In other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Director	10e. Street and Number	1	10f	. Zip Code		10g.	Citizen of What C	ountry?
eath v	Funeral	11. Marital Status	HVCNUC 12. Was Decedent Ever in U	J.S. 13. Was D	2/2	19 Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Am	erican Indian,
after d		1 □ Never Married 2 □ Married	Armed Forces? 1 Ves 2 No If Yes, Give		specify Cub es 2 No	Hispanic Origin? (Spoan, Mexican, Puerto Specify:	Rican, etc.)	Black, Whi	ite, etc.
hours ural",	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates: WW.	4			100	Specify: W	Lite
9	plete	15. Decedent's E (Specify only highest gra	ade completed)	16a. Decedent's (Give kind o life. DO NO	f work done	during most of work	ing 160	o. Kind of Business	s/industry
ed within giene. er than " the Mec	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Bo	ats 1	Mate		U.S. N	ary
be file stal Hy ad oth event	Be	17. Father's Name (First, Middle, Last		,		18. Mother's Name	e (First, Middle, Mai	den Surname)	1 10
should and Mer marke umatic	욘	19a, Informant's Name/Relationship	Mc Cardell (Type, Print)		Iress (Street	t and Number or Rui	al Route Number, C	<u> ハヒ </u>	Zip Code)
1 and 2 should be filed withing 1 and 2 should be filed withing the filed withing 1 and 2 should be filed withing 1 and 2 shou		Zelda McCarde	11 - Wife	2322 K	Puth	Avenue.	Edgeme 200	Re MI	21219
S = = = = = = = = = = = = = = = = = = =		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		Place of Disposition cemetery, crematory	(Name of		Date 200	c. Location - City o	r Town, State
		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice	(y) (170	arrison F	0/25	ess of Facility R	2-08 0	WINGS /L	11/5, MD
permit. Departr Imports any Inj		21. Signature of Furieral Service Lice	Isee	Hoa	p_{e} \mathcal{P}_{e}	4 2134	willow	HSK FON	FUNERAL Od 2122.2
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dear	th. Do not enter the	mode of dyi	ing, such as cardiac		ping	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death)	a Carcinema-L	una Basa	1 Cell				Onset and Death
/Medical Examiner			Due to (or as a consec	queno d'):					
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consec	quence of):					
be executed clan and curial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consec	ruence of).					
			d.	querios ory.					
eath certificate be e. attending physician for use as the buria	Physician/Medica		5 , U						
ath cer ttendir or use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregn 1 ☐Live birth 2 ☐ Fet	al death 3 □Ector	oic pregnanc	су		23d. Date of de Month	elivery Day Year
that the dened by the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of o 9□Unknown	death 5∐Othe	r (specify) _				
The law requires that the death certificate the has been signed by the attending physage 2 should be detached for use as the	by Ph	Part II. Other significant conditions	contributing to death but not res	sulting in the underly	ing cause gi	ven in Part I.	23e, Did tobac	co use contribute	to the cause of death?
w require been sig should b							1 ☐ Yes		Probably 4 Unknown
has be	Completed						24a. Was an autopsy performe	24b. Were a prior to death?	autopsy findings available completion of cause of
	e Co	25. Was case referred to medical				26. Place of Deat	1 Yes 2 h (Check only one)	No 1 ☐ Ye	es 2 No
	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: Inpatient 2	ER/Outpatient 3	DOA Ot	hor	ome 5 ☐ Residenc	e 6 □Other (Sp	ecify)
ling P		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo	ıryat ork?]Yes 2∐No	28d. Describe how	injury occurred	
Attending Physician: r death. ector: After this certific. by the funeral director, I	ficat	2 Accident investigatio 3 Suicide 6 Could not b	e 28e. Place of injury - At h	l nome, farm, street, fa			28f. Location (Stree	et and Number or I	Rural Route Number,
tal or is after al Direct	Certification:	4 ☐ Homicide determined	building, etc. (Speci	ify)			City or Town, S	State)	
To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.	Medical		hysician: To the best of my knimer: On the basis of examin and manner stated.						
To the within 5	Mec	29b. Signature and title of gentitor		\	29c. Licen	se number	29d	. Date signed (Mo	nth, Day, Year)
		MARINE	My sallue		MDO	72692L	25	3 March	106
4+1		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type, Print)	1110	10-0	Van D	Dila	100 100 100 100 100 100 100 100 100 100
Sta	te	31. Date filed (Month, Day, Year)	32. Resistrar's Sign	aty and It	earth	Care sys	tem, terry	roint, 1	ND 21902
Regist	_	MAR 3 1	2008 Marie	It Agoas	de la				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 0420 PM Rose MARINO MARCH MARION 29 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** UNIVERSITY OF MARYLAND MEDICAL CENTER BALTIMORE CITY 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Social Security Number 8. Sex Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🕱 F Director 216-36-9581 7/05/1933 MASSACHUSETTS Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits a or 28a-f sh 1 ☐ Yes 2 XNo Director MD CARROLL WESTMINSTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a e 712 GORSUCH RD. 21157 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE 12 HOME MAKER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ont of Health and Mental H tt. If item 27 is marked oth y or other traumatic even Be RICHARD KOURY ADELE DAVID ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VINCENT S. MARINO -HUSBAND 712 GORSUCH RD., WESTMINSTER, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or 4 Donation 5 ☐ Other (Specify)

21. Signature of Euleral Service Licensee 5 ☐ Other (Specify) EVERGREEN MEM. GARDENS 4/3/08 FINKSBURG. 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. 254 E. MAIN ST., WESTMINSTER, MD 21157 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** INTERCRANIAL HEMORRHAGE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) s been signed by the s 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has b irector, page 2 sh 24a, Was an performed 2 No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ this 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3□ Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) - 3. Rute MA P21136 MARCH 29 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE ND 21201 22 SOUTH GREENE ST. NORMAN RETENER MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 3 1 2008 Registrar

08-02316	
Daniel Manson	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1- For State Registrar	•	tificate of		id Wichtai Ti	, ,	J. No. 20	08 1020
Medi	Physici cal Exami	~	1. Decedent's Name (First, Middle,Last)					2. Date of Death Month March 24, 2	Day Year	3. Time of Death 0510 hrs
ml she		أثر	Daniel Maxim Manson 4a. Facility Name (if not institution, give street and nur	nber)	14	b. City, Town, o	r Location of Deatl		4c. County of D	eath
?			St. Agnes Hospital			Baltimore				
	Funeral			7. Age (In yrs. la	ast birthday)	If Under 1 Ye		,	F	. Birthplace (State or oreign
	Director		456-25-0268 1XM 2 F		49 Yrs.		yo modio min	Februa	ary11,19	959try) Israel
	any		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Locati	on				10d. Inside City Limits
		5	Maryland Howard	El	kridge	:				1 Yes 2 No
	Maryla 28a-f dato	rect	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?
1	th the 23a or notifie	Ö	6330 Washington BLVD			21075			J.S.A.	5
Ch	Dailtimofe, INID 21219-0030 permit. Pages I and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hysiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	1 Never Married 2 X Married Armed Fo				ispanic Origin? (S an, Mexican, Puert		14. Race - A White, e	merican Indian, Black, tc.
10	ifter de Il", or		3 Widowed 4 Divorced If Yes, Give Year	2 No	1	Yes 2X N	o specify:		Specify: W	nite
/	hours a natura Exami	ed by	15. Decedent's Education (Specify only highest grad				ation (Give kind of e. DO NOT use re		16b. Kind of Busin	ess/Industry
ć	So iin 72 ihan " diral I	Completed	Elementary/Secondary (0-12) College (1-	4 or 5+)	Sales	person	1		Commun	ication
6	Z1Z15-UU36 vuld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Som	17. Father's Name (First, Middle, Last)			Forott		e (First, Middle, M		
2	be fill mtal H irked	Be	Michael Manson					a Halle		
	Should should and Me	ဥ	19a. Informant's Name/Relationship (Type, Print)		1					State, Zip Code) 9002
3	and 2 ealth a tem 27 traum		Michael Manson 20a. Method of Disposition	20b. F	1432 Place of Dispos	S. Sal	tair Ay	Zenue# Z	20c. Location - Ci	ngeles, CA. ty or Town, State
	TOFE ages 1 at of H t: If i		1 X Burial 2 Cremation 3 Removal from	m State MT	rematory or oth Sinai	ner place) Memori	alPark3	30-08	LosAnge:	log CA
1	BAILIMORE, IMD bermit. Pages I and 2 sh Department of Health and Important: If item 27 is injury or other traumat	1	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee		22. N	lame and Addres				Chapel, P. A
Ċ	iii iii Der Q		michael P. marsullo		60	09Harf	ord Roa	d.Balti	imore, Ma	aryland21214
F	Physician /Medical		23a. Part I. Enter the disease, or complications that ca failure. List only one cause on each line.	used the death.	. Do not enter th	ne mode of dying	g, such as cardiac	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
J	xaminer		Immediate Cause (Final disease or condition resulting in death) a. Atherosc Due to (or as a			cular dis	0000		_	Death
	/		Sequentially list conditions, b.							
		iner	if any, leading to immediate Due to (or as a cause. Enter Underlying Cause	consequence of	f):					
	ı, it	Examiner	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a	consequence of	f):					
	f 6U, icate be executed physician and the burial - transit		d.							
9	e be ex	Medical	IF FEMALE: AMENDED #23a, 27	perME,g	379, 5/8 <u>/</u>	08 TT			23d. Date of de	livon
0.00	rtifical ing ph as the		23b. Was decedent pregnant in the past 12 months?			tal death 3	Ectopic pregr	ancy	Month Month	Day Year
	eath ce attend for use	sician/	1 Yes 2 No 9 Unknown g Unknown	ant at time of de	ath 5 Ot	her (Specify)				
	by the ached	Phy	Part II. Other significant conditions contributing to	•	esulting in the u	ınderlying cause	given in Part I.	23e. Did tot	pacco use contribu	te to the cause of death?
	ires that signed be def	d by						1 Yes	2 No 3	Probably 4 V Unknown
	oras w requ s been should	olete						24a. Was a autops	sy pric	re autopsy findings available or to completion of cause of
	The lar	Completed						perform 1 ✓ Yes 2		th? Yes 2 No
1	cian: certifi ector,	Be	25. Was case referred to medical examiner?				Other Nurs			
7,4	Physi Physi er this	유	1 Yes 2 No "	npatient 2 🗸	ER/Outpatient 28b. Time of I		jury at Work?		Residence 6 ow injury occurred	Other:
	on con control	tion	1 X Natural 5 Pending (Month,	Day,Year)			Yes 2 No			
	VIST or Atte fter de: Directo in by t	ifica	2 Accident Investigation 3 Suicide 6 Could not be	of Injury - At ho	ome, farm, stree	et, factory, office	building, etc.	28f. Location (S or Town, St		or Rural Route Number, City
ä	spital cours a filled filled	Certification:	4 Homicide determined (Specify)					or rown, st	ale)	
	LIVISION OI VICAL RECORDS, P.O. BOX 86/00, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi		29a, Certifier (Check only one) 2 Medical Examiner: On the basis of	-	-					
	To t with To t	Medical	and manner st 29b. Signature and title of certifier				nse number			(Month, Day, Year)
			Theodow WA W.	201	_	0.0	c.M.E.	OCME	March 25, 20	800
		1		e of death (Item	23a)					
				nt Medical E		111 Penn S	treet, Baltimo	re, MD 21201		
	St Regis	tate	31. Date filed (Month, Day, Year) 32. Re MAR 3 1 2008	gistrar's Signatu	ire Constant	,				

08-02054 Angela Nicely Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ngela Nicely	F	- For State Registrar	ate of Maryla		partment of Certificate of		and	Menta	l Hyg		Reg. No.	20	08	1020
Physician Medical Examin		1. Decedent's Name (First, Middl Angela Nice			-					Date of De Month March 1	Day	Year		e of Death 55 hrs
ı		4a. Facility Name (if not institution		umber)	4	b. City, Tov	vn, or Lo	cation of D		viai Cri Ti		. County of De	ath	
		Harbor Hospital Cente				Baltimo							5:11	70
Funeral Director	1	5. Social Security Numbe unk	6. Sex	7. Age (In yr	s. last birthday)	Months Months		Hours		Oct			Birthpiace Country)	(State or Foreign unk
<u>-</u>	-	Usual Residence of Decedent 10a. State UNK 10b. County		110 H10c C	City, Town or Location	n .						1-	10d1h	nside City Limits
d now any		Toa. State CLTR Tob. County		ulik loc. c	oity, fowir or Location	JII						unk		Yes 2 No
death with the Maryland or items 23a or 28a-f show must be notified at once.	Director	10e. Street and Number			unk	10f. Zip C	ode		1	unk	10g. Citi:	zen of What C	ountry?	
3a or 2												USA		
or items 2	Funeral		nk 12. Was De arried Armed F	cedent Ever in orces?		Decedent s, specify					No-	14. Race - An White, etc		tian, Black,
Rer de		3 Widowed 4 Div	1 Yes	2 No		Yes 2 X	No .	specify:				Specify:	white	
hours a	ed by	15. Decedent's Education (Spe			i) 16a. Decedent	's Usual Od	ccupation	n (Give kin	d of worl	k done uj	16b. i	Kind of Busine	ss/Industry	unk
36 hin 72 le. c. than "-	Completed	Elementary/Secondary (0-12) unk	College (1-4 or 5+)			-							
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	5	17. Father's Name (First, Middle	, Last)			unk	18	.Mother's N	Name (F	irst, Middle	e, Maiden	Surname)		unk
	8	19a. Informant's Name/Relations	hin (Type Deint)		10h Mailing	Addross	/Stroot o	and Numbe	e or Pur	al Pouto N	lumbor C	ity or Town, S	tate 7in C	ode)
MD 2 nd 2 shoul alth and N m 27 is n aumatic	-	O.C.M.E.	ilip (Type, Fillit)		111 P							21201	ate, zip o	ode,
re, N I and FHealth Fitem er trau		20a. Method of Disposition 1 Burial 2 Cremation	n 3 Removal f		Ob. Place of Disposi crematory or oth		of ceme	tery,	Г	Date	20c.	Location - City	or Town,	State
Baltimore, permit. Pages 1 ar Department: of the Important: of the injury or other tr	Į	4 Donation 5 Y Other S	pecify: in st											
Balt permit Depart Impor		nature of Furral Service	S. Made,	Direct	or St	ame and A ate A ltimo	^{ddress} o nato	f Facility my Bo MD	pard 2120	655	W.B	altimo	re St	reet
Physician	1	23. Part I. Enter the discusse, or		caused the de	eath. Do not enter th	e mode of	dying, su	ich as card			arrest, sho	ock, or heart		roximate Interval
/Medical	1	failure. List 'nly one cause Immediate Cause (Final disease	a. Methado		xication an	d Coca	ine u	se wit	h Con	plicat	tions			Death
	1	or condition resulting in death)	Due to (or as	a consequenc	ce of):									
	힐	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		a consequenc	ce of):									
	Examin	(Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequenc	pe of):									
xecuted n and I - transit		X UNPENDED	d	232 27	,28a-f per l	ME 9878	8 4/1	1/08 a	mh					
60, ate be exe hysician a	Medical	IF FEMALE:				.II gor	J 4/ I	1, 00 a			23	d. Date of deli	very	
Box 6876(The death certificate the attending physical for use as the b	Physician/M	3b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year											Year	
Box death of	SS	1 Yes 2 No 9 V Un	7		or death 5 Oti	ner (Specii	(y)							
, la & a l	2 2	Part II. Other significant condit	tions contributing	to death but n	ot resulting in the u	nderlying o	ause giv	en in Part	l.		_	use contribut		use of death? 4 ✓ Unknown
rds, Frequires			<u>.</u>							24a. W		24b. Wer	e autopsy	findings available
Division of Vital Records, as after death. The law requires and prysician: The law requires and present and prector: After this certificate has been sided in by the funeral director, page 2 should be a should	Completed							_	-	pe	rtopsy erformed? es 2 1	deat		etion of cause of
Vital Reco		25. Was case referred to medica				26	.Place o	f Death (C	heck on			10 1	163	
'Vita	lo Be	examiner? 1 Yes 2 No	Hospital: 1	Inpatient 2						Home 5			ther:	
n of ding Ph.		27. Manner of Death 1 Natural 5 Pene	din .	e of Injury h, Day,Year)	28b. Time of li			atWork? s 2.∏N	lo _		be how in	jury occurred		
r Attender death irector:	ertification:		stigation Fnd	3/13/08 ce of Injury - A	Unk At home, farm, stree							and Number o	r Rural Ro	ute Number, City
Division Sepital or Attent hours after death nneral Director: y filled in by the		4 Homicide dete		Harbor I	Hospital Ce	nter			30	or Town	n, State) Hanove	er St.,Be	altimo	re,MD
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: Completely filled in by the		29a. Certifier 1 Certifying P	hysician: To the be miner:On the basis	est of my know	viedge, death occur	red at the t	ime, date	e and place death occu	e, and do	ue to the c	ause(s) a	nd manner as	stated. to the caus	se(s)
Totl withi Totl com	Medical	29b. Signature and title of certific	and manner	stated.			License					. Date signed		
		The day 111	7440		. A		O.C.M	.E.	OCN	ić.	Ма	rch 14, 20	80	
	ŀ	30. Name and address of person			ŕ	444.5:	C4-	-t D-111	ma	MD 244	201			
Sta		Theodore M. King, Jr.		ant Medica Registrar's Sign	al Examiner	111 Per	ın Stre	et, Balti	more,	IVID 212	201			
Sta Registr	ar	31. Date filed (Month, Day, Year)	2008	College.	A POR	302								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March **Physician** 26ª 2008a Antoinette Α. 5:00 a M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 27 Stonefall Court Baltimore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea 1/14/1917 **Funeral** Days Year Hours 1 □ M 2 🛛 F 212-90-7072 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 ☐Yes 2 No Director Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be 1 once. USA 21236 27 Stonefall Court Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: White ۵ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dwn Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alavera Monica Ciceri Gerome ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21236 Baltimore, Maryland 27 Stonefall Court Barbara Pac / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Rosary Cemetery 4/2/2008 Baltimore, Maryland 21. Signature of units Service Lie 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 051 /Medical Due to (or as a consequence of) **Examiner** outhi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a ou Examine wells To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Q Q 1 Yes 2XNo 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b director, page 2 s' autopsy performed? 1□ Yes 2□No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death | Director: / d in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi 27/08 and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar's Signature State MAR 3 2008 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 7:50 AM Zbigniew Piatek MARCH 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** SAMAR ITAN HOSPITAL BALTIMALE GOOD If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Feb 15, 1928 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☑ M 2 □ F 086-32-6236 80 Poland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified at 1 ☐ Yes 2 No Director Harford Md. Abingdon 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code natural", or items 23a or!' اعلاما Examiner must be r 401 Arrow Wood Court 21009 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ZYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) 4yrs Elementary/Secondary (0-12) Self-employed Chemist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked o <u>Mieczyslaw Piatek</u> <u>Zofia Musial</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Piatek (wife) 401 Arrow Wood Court Abingdon, Md. 21009 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 3-31-2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilit Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licenses Tolar 1201 Dundalk Ave. Baltimore, Md. 21222 23a. Part1. Enter the diseale, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Diesacs of Lighty that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4□Pregnant at time of death detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown ALTERY DISCHOOL 1 Tes CORDNARY 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No CHRONIC KIDNEY DISCORSE REST KATONY FAILURE 1 Yes COPD 2410 the Hospital or Attending Physician: the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA မ 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of c ATTONDING DOO 60039 2001 MARCH 25 PHYSIC (N) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAW NAING

DHMH 17 Rev 1/2001

State Registrar

1041

6000

31. Date filed (Month, Day,

SAMAR 17AD

year)

HOSPITM

Registrar's Signature

BACTIMORCE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Frances Posinski /Medical 4b. Cify, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Doctors Community Hospital Lanham Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept 15, 1927 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6 Sex 5. Social Security Number **Funeral** Months 1 M 2 XF 212-24-7693 80 Maryland Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural" or Items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 Yes No Director Md. Prince George's Bowie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 13220 Idlewild Drive 20715-1406 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White permit. Pages 1 and 2 should be filed within 72 hours a Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural any injury or other transmission." þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department Elementary/Secondary (0-12) College (1-4or 5+) Intelligence of Defense 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Baltimore, Maryland Be Francis Posinski Melania Hepner ပ 19a. Informant's Name/Relationship (Type. Pr(mhephew) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernard Anthony Posinski 1556 Clairidge Rd. Baltimore, Md. 21207 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State St.Stanislaus Cem 3-31-2008Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility aczorowski Funeral Home, PA 21. Signatury of Funeral Service Licenses 1201 Dundalk Ave. Baltimore, Md. 21222 23a Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Renul **Physician** /Medical Due to (or as a consequence f): Examiner epho Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Medpir ator or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran. Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an certificate 1☐ Yes 2 NO 25. Was case referred to medical Be 26. Place of Death Check onl one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 11 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this nours after death.

neral Director; After this

filled in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury **1** □ Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 T Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aff To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MBS 60925 3

Registrar

State

514687

SUITE 351 LAUKEL, MD 20707

575 MAIN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32 Registrar's Signature

FASIKA

ELIZAGETH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Eunice Perkinson 10:50A M /Medical March26,2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Howard County General Hospital

5. Social Security Number | 6. Sex | 7. Age (In vrs. last birthda Columbia
Under 1 Year | ff Under 24 Hrs. | 8. Date of Birth
(Month, Day, Year) Howard Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🔀 F 288-09-9716 Director Ohio July12,1919 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Carroll Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21784 405 Carroll Street U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give⁺ Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 📉 No Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dollie Dollerhie James Curnayn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 405Carroll Street, Sykesville, Maryland 21784 Sharon Quinter/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-28-08 Baltimore, Maryland Bayview Crematory: 21. Signature of Funeral Service Livensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 6009 Harford Road, Baltimore, Maryland 21214 23a. Part1. Pirter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate cause (Final disease condition result in death) Hemorrhage with Herniation **Physician** Intracranial /Medical Examiner Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and the burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ひゃナドムチis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed epression certificate has birector, page 2 s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy DYSFUNCTION 59. 1∐ Yes 2 No 1 ☐ Yes 2 XNo To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury fall March 25,2008 unknown 1 ☐ Yes 2 X No after death Director: 2 Accident completely filled in by the 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Dr. City or Town, State) 29,7 Mt. Clarve Dr. Ellicot CTy Md. 21043 4 T Homicide Assisted Living racilit 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

DHMH 17 Rev 1/2001

Trimble Hill

atherville, MI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

31. Date filed (Month, Day, Year)

MAR 31

MI

4

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 15 **Physician** March ∠)M /Medical 4a. Facility Name (If not institution, give 4b. City, Town, or Location of Death 4c. County of Death street and number Examiner Itimore Baltimore //{ Medical enter 8. Date of Birth (Month, Day, Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 X M 2 □ F 500 26 9776 80 Feb. 26, 1928 Director Missouri Usual Residence of Decedent 10c. City, Town or Location 10a State 10h County 10d Inside City Limits show ral", or Items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Dundalk Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 USA 3316 Wallford Drive death \ by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: ₩W II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Iter 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☒ No 3altimore, Maryland 21215-0036 Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Soldier U.S. Military 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Alice Goran Albert Clyde Remley 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3316 Wallford Drive Baltimore, Maryland 21222 Audrey Remley (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of Important: If Its any Injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/31/2008 Maryland Veteran's Crownsville, Maryland 4 Donation 5 Dother (Specify) Sign Aure of Funeral Service L 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 W. ohn 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition as resulting in death) WILLIAM A PROVED BY MEDICAL EXAMINER /Medical Due to ker as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine the death certificate be executed burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of) physician Physician/Medical as the attending p IF FEMALE yes, outcome pf pregnancy □Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 1 ☐Live birth in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 2 No 9 Unknown 9 Unknown The law requires that signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 1 ☐ Yes 2∏ No 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an has autopsy performed' certificate 2 0 No Attending Physician: After this certific funeral director, 25. Was case referred to medical examiner? 1 ☐ es 2 ☐ No 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 25/00 1 ☐ Yes 2 👿 No death. UNK octhroom 2 Accident 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760, To the Hospitallor Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu within 24 hours

44

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifie

29c. License number

1 Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

0501

29d. Date signed (Month. Dav. Year)

Greene

10N.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GREENE ST BALTIMORE, MARYLAND

egistrar's Signature 31. Date filed (Mo)

and manner stated.

Oscar Laso Rivas

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Registrar 1. Decedent's Name (First, Middle,Last) Oscar I Rivas 4a. Facility Name (if not institution, give street and number) Prince Georges Hospital 5. Social Security Numberunk Funeral Director Funeral Director Funeral Director Oscar I Rivas 4a. Facility Name (if not institution, give street and number) Prince Georges Hospital 5. Social Security Numberunk Oscar I Rivas 1. March 3, 4b. City, Town, or Location of Death Cheverly Funder 1 Year If Under 24Hrs. Months Days Hours Min. Dec I Usual Residence of Decedent 10a. State Unk 10b. County 10b. County 10c. City, Town or Location 10c. City, Town or Location 10d. State Unk 10b. County 10d. City, Town or Location 10d. State Unk 10b. County 10d. City, Town or Location 10d. State Unk 10b. County 10d. State Unk 10b. County 10d. State Unk 10b. County 10d. City, Town or Location 10d. State Unk 10b. County 10d. State Unk 10b. County 10d. State Unk 10b. County 10d. City, Town or Location 10d. State Unk 10b. County 10d. City, Town or Location 10d. State Unk 10b. County 10d. City, Town or Location 10d. State Unk 10b. County 10d. City, Town or Location 10d. State Unk 10b. County 10d. City, Town or Location 10d. State Unk 10b. County 10d. City, Town or Location 10d. State Unk 10b. County 10b. County 10d. City, Town or Location 10d. State Unk 10b. County 10b.	Day Year 2356 hrs 4c. County of Death Prince George's Sirth(MM/DD/YYYY) 9. Birthplace (State or un Foreign Country) 10. 1977 unk 10d. Inside City Lin unk Yes 2 10g. Citizen of What Country? unk No- 14. Race - American Indian, Black, White, etc. Specify: White
March 3, 4a. Facility Name (if not institution, give street and number) Prince Georges Hospital 5. Social Security Numberunk Director 5. Social Security Numberunk 1	4c. County of Death Prince George's Sirth(MM/DD/YYYY) 9. Birthplace (State or un Foreign Country) 10 1977 Unk 10d. Inside City Lin unk Yes 2 10g. Citizen of What Country? unk No- 14. Race - American Indian, Black, White, etc. Specify: White
4a. Facility Name (if not institution, give street and number) Prince Georges Hospital 5. Social Security Numberunk 1	Prince George's Birth(MM/DD/YYYY) 9. Birthplace (State or un Foreign Country) Unk 10d. Inside City Lin unk Yes 2 10g. Citizen of What Country? unk No- 14. Race - American Indian, Black, White, etc. Specify: White
Prince Georges Hospital 5. Social Security Numberunk 6. Sex 1 X M 2 F 30 Yrs. Usual Residence of Decedent 10a. State UNK 10b. County Cheverly If Under 1 Year If Under 24Hrs. 8. Date of Bit Months Days Hours Min. Dec 1	9. Birthplace (State or un Foreign Country) 10. 1977 unk 10d. Inside City Lin unk 10g. Citizen of What Country? unk 14. Race - American Indian, Black, White, etc. Specify: white
Funeral Director 5. Social Security Number Unix 5. Sex 1. Age (iii yis. let states) 1 X M 2 F 30 Yrs. Months Days Hours Min. Dec 1 Usual Residence of Decedent 10a. State Unix 10b. County Unix 10c. City, Town or Location	unk 10d. Inside City Lin unk 10d. Inside City Lin unk Yes 2 10g. Citizen of What Country? unk No- 14. Race - American Indian, Black, White, etc. Specify: white 16b. Kind of Business/Industry un
Usual Residence of Decedent 10a. State Unk 10b. County 1 X M 2 F 30 Yrs. Dec 1	unk 10d. Inside City Lin unk Yes 2 10g. Citizen of What Country? unk No- 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry un
10a. State unk 10b. County unk 10c. City, Town or Location	10g. Citizen of What Country? unk No- 14. Race - American Indian, Black, White, etc. Specify: white 16b. Kind of Business/Industry un
a louis date dates	10g. Citizen of What Country? unk No- 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry un
The Warvier of the Maryland of the Cool of the Maryland of the Cool of the Maryland of the Cool of the Maryland of the Cool of the Cool of the Cool of the Maryland of the Cool of the Cool of the Cool of the Cool of the Cool of the Cool of the Cool of the Maryland of the Cool of the Cool of the Cool of the Cool of the Maryland of the Cool of the Cool of the Cool of the Cool of the Maryland of the Cool of the Cool of the Maryland of the Cool of the Cool of the Cool of the Maryland of the Cool of the Maryland of the Cool of the Cool of the Maryland of the Cool of the Maryland of the Cool of the Maryland of the Cool of the Maryland of	No- 14. Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry un
10e. Street and Number 10e. Street and Number 10e. Street and Number 10e. Street and Number 10e. Street and Number 10e. Street and Number 10e. Street and Number 10e. Street and Number 10e. Street and Number 10e. Street and Number 11e. Marital Status 11. Marital Status 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12e. Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12e. Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12e. Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12e. Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12e. Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12e. Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 12e. Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 12e. Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 12e. Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 12e. Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 12e. Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 12e. Was Decedent Suban Color of If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 12e. Was Decedent Suban Color of If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 12e. Was Decedent Suban Color of If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 12e. Was Decedent Suban Color of If Yes, Specify Cuban, Mexican, Puerto Rican, etc.) 12e. Was Decedent Suban Color of If Yes, Specify Cuban, Mexican, etc.) 12e. Was Dec	No- 14. Race - American Indian, Black, White, etc. Specify: White
The part of the pa	white, etc. Specify: white 16b. Kind of Business/Industry un
11. Marital Status 12. Was Decedent even in J.S. 13. Wared Forces? 14. Yes 2 No 15. Decedent's Education (Specify only highest grade completed) 15. Decedent's Education (Specify only highest grade completed) 15. Decedent's Education (Specify only highest grade completed) 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Name)	Specify: white
The sum of the state of the sta	16b. Kind of Business/Industry un
To Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 17b. Decedent's Education (Specify only highest grade completed) 17b. Decedent's Education (Specify only highest grade completed) 17b. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 17b. Decedent's Education (Specify only highest grade completed) 17b. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 17b. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 17b. Decedent's Education (Specify only highest grade completed) 17b. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 17b. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 17b. Mailing Address (Street and Number or Rural Route North College (1-4 or 5+) 17b. Mailing Address (Street and Number or Rural Route North College (1-4 or 5+) 17b. Mailing Address (Street and Number or Rural Route North College (1-4 or 5+) 17b. Mailing Address (Street and Number or Rural Route North College (1-4 or 5+) 17b. Mailing Address (Street and Number or Rural Route North College (1-4 or 5+) 17b. Mailing Address (Street and Number or Rural Route North College (1-4 or 5+) 17b. Mailing Address (Street and Number or Rural Route North College (1-4 or 5+) 17b. Mailing Address (Street and Number or Rural Route North College (1-4 or 5+) 17b. Mailing Address (Street and Number or Rural Route North College (1-4 or 5+) 17b. Mailing Address (1-4 or 5+) 17b. Mailing Address (1-4 or 5+) 17b. Mailing Address (1-4 or 5+) 17b. Mailing Address (1-4 or 5+) 17b. Mailing Address (1-4 or 5+) 17b. Mailing Address (1-4 or 5+) 17b. Mailing Address (1-4 or 5+) 17b. Mailing Address (1-4 or 5+) 17b. Mailing Address (1-4 or 5+) 17b. Mailing Address	un
The second and the second and sec	
unk unk 17. Father's Name (First, Middle, Last) unk life event, the Wedlar Holder of the drawn the well and the first wind the well and the well a	e, Maiden Surname) 1111
17. Father's Name (First, Middle Last) 17. Father's Name (First, Middle Last) 18. Mother's Name (First, Middle Last) 19. Mailing Address (Street and Number or Rural Route Name (First, Middle Last)	e, Maiden Surname) un
To plan and the pl	
The property of the property o	Number City or Town, State, Zip Code)
O.C.M.E. 111 Penn Street Baltimore O.C.M.E. 203 Method of Disposition 204 Place of Disposition (Name of cemetery.) Date	20c. Location - City or Town, State
20a, Method of Disposition (Name of Centerly, crematory or other place)	
E a bear and Address of Facility	
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donatton 5 X Other Specify: in state 21. Si. a ure of Funeral Service Liven e Ronald Pirector 22. Name and Address of Facility State Anatomy Board 655 Method of Disposition and address of Facility 23. Name and Address of Facility 24. Name and Address of Facility 25. Name and Address of Facility 26. Name and Address of Facility 27. Name and Address of Facility 28. Name and Address of Facility 29. Name and Address of Facility 20. Name and Address of Facility 21. Si. a ure of Facility 22. Name and Address of Facility 23. Name and Address of Facility 24. Donaton by Board 655 Method of Disposition and Address of Facility 25. Name and Address of Facility 26. Name and Address of Facility 27. Name and Address of Facility 28. Name and Address of Facility 29. Name and Address of Facility 20. Name and Address of Facility 20. Name and Address of Facility 20. Name and Address of Facility 21. Name and Address of Facility 22. Name and Address of Facility 23. Name and Address of Facility 24. Donaton by Board 655 Method of Barbard 1 and	W. Baltimore Street
light to the equipped the death. Do not enter the mode of dying, such as cardiac or respiratory	arrest, shock, or heart Approximate Int
tailure. List only one cause on each line.	Death
Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	
D	
Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	
events resulting in death) Last d.	
d. Daduadu I. da and and an and an and an and an and an and an and an and an and an and an an an an an an an an an an an an an	
o a size of the si	23d. Date of delivery Month Day Yea
FEEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Pregnant at time of death 5 Other (Specify) 9 Unknown Part II. Other significant conditions 23e. D 23e. D	World Bay
Yes 2 No 9 Unknown 9 Unknown 9 Unknown 23e. D	
M 9 कुछ दे Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	Did tobacco use contribute to the cause of deat
O. G. state of the	Yes 2 ✓ No 3 Probably 4 Unkr
Records, The law requires Tomble ted Completed Completed 26. Place of Death (Check only one)	Was an 24b. Were autopsy findings av autopsy prior to completion of cau
lab lab lab lab lab lab lab lab lab lab	performed? death? Yes 2 No 1 ✓ Yes 2
W L L L L L L L L L L L L L L L L L L L	
THE STATE OF THE S	5 Residence 6 Other:
24a. V 1 V 24a. V 24a. V 25. Was case referred to medical examiner? 1 V Yes 2 No 25. Was case referred to medical examiner? 1 V Yes 2 No 26. Place of Death (Check only one) 27. Manner of Death 28d. Description 28d.	cribe how injury occurred rian struck by auto
28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28b. Time of Injury 28c. Injury at Work? 28c. Injury at Work? 28c. Injury at Work? 28d. Date of Injury 28d. Date of Injury 28d. String of Injury 28d. String of Injury 28d. Time of	2000 227-1-052 700
10 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ntion (Street and Number or Rural Route Number own, State)
Notice of the part	est Highway and Taylor Street, Riverdale
	e cause(s) and manner as stated.
Set the life of the late of th	, date and place, and core
296. Signature and title of certifier	29d. Date signed (Month, Day, Year)
O.C.M.E.	March 4, 2008
30. Name and address of person who com toted cause of death (Item 23a)	
Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State 31. Date filed (Month, Day, Year) MAR 3 2008	

				For Stata Registrar		State of	Maryla				ealth and Death	Mei		giene Rag. No.	308	10	203
		Dhinte		1. Decedent's Nam	ne (First, Middle, La	ast)					<u> </u>	2.	Date of Dea		Year	3. Time	of Death
		Physici /Medio			Reynol							1	Parch	7 23	300	11:	55 P™
-	,	Examir	ner	4a. Facility Name ((If not institution, gi		iber)		4b. City	, Town, or	Location of Dea	ath		4c. C	ounty of Dea	t 0 1	
	- 98 - 1	Francis I		5. Social Security	Number 6.	CINOV	7. Age (In vrs	. last birthday)	If Unde	r 1 Year	If Under 24 H	s. 8.	Date of Birt		9 Bin	holace (Sta	te or Foreign
		Funeral Director		218-12-1		1□M 2 X F	84		Months	Days	Hours Mir	n.	(Month, Day	(, Year)	Co	yland	o or roragir
		p .		Usual Residence of	of Decedent		100 0	ity, Town or Lo									01. (1.1)
		laryla ehov	ō	10a. State MD	10b. County Somerset	;		incess		2							City Limits
		28a-f	rect	10e. Street and Nu	ımber					p Code				10a Citiza	n of What Co		A-
		death with the Maryland me 23a or 28a-f ehow r must be notified at	0		ld Prince	ss Anne	Road		101121		21853			US			
_		mme 2	Funeral Director	11. Marital Status		12. Was Dece	dent Ever in t	U.S. 13.	Was Dece	dent of Hi	spanic Origin? (n, Mexican, Pue	(Specification Rich	y Yes or No-	14	Race - Ame Black, Whit		1
55pm	36	or Its	by Fu		ried 2 Married 4 Divorced	1 ☐ Yes If Yes, Give	2 X) No ∋		1 🗆 Yes		Specify:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	411, 010.)		pecify: wh		
3	8	tural Ex	ed b	3 134VIdowed	15. Decedent's E	Year or Da	tes:	16a. Dece	dent's Usu	al Occupa	ation				of Business		
5	215	hin 72 n "na Merik	Completed	(Spe Elementary/Sec	cify only highest gr		4or 5+)	(Give	kind of wo DO NDT u	ork done d ise retired	furing most of w)	orking		100.11110	01 500111000	industry	
_	21	ed wit	E OS	11	oridary (5 12)	0		h	omema	aker				OW	n home		
	pu	tal Hy d oth	Be		(First, Middle, Last						18. Mother's Na				imame)		
M	7	d Mer narke	ဥ		Henry B			10h Mail:		. (01-1-1			san Pa			T. O. (1)	01050
Ã	Ma	id 2 si Ith an 27 Is r treur			eynolds/d						ind Number or A			-			21853
Ŕ	ē,	f Healitem		20a. Method of Dis	sposition			Place of Dispo	sition (Na	me of		Date			tion - City or		
3.38-3008	E	Page nent o int: If			□ Cremation 3 [5 □ On r (Speci		state	cometery, crei	natury or t	ourer prace	9)						
'n	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Itame 23a or 28a-f ehow any injury or other treumatic event, Ira Madical Examiner must be notified at once.		21. Signature of F	uneral Service Lice	wave, b	irecto	r St	Name ar ate altim	Anato	omy Boar MD 212	cd 6	55 W.	Balt	imore	Stree	t
	. £	8		23a. Part 1. Enter	the disease or con art failure. List only	plications that ca	used the dea						spiratory ar	rest,		Approxir Interval	
4	fo	Physician		Immediate Cause disease or condition	(Final on			Asa	(1)							Onset ar	nd Death
***		/Medical Examiner		resulting in death)	(Due to (c	or as a conse	quence of):								7	
	6	- Administra	1	Sequentially list co	onditions,	b. — Due to lo	or as a conse	uence of									
		uted Insit	Examiner	Cause (Disease or	erlying r injury	Due to to	n as a conse	cineurse ord									
	ć	ate be executed hysician and the burial-transit	Еха	that initiated event resulting in death)	Last	c. Due to (c	or as a conse	quence of):									
	8760,	2 S S	icai			d											
. 0	9	certifica Iding ph	Med	IF FEMALE:								-					
de	Вох	feath certifica attending ph for use as th	Physician/Medical	23b. Was deceder in the past 12			th 2 Fet	al déath 3 □	Ectopic p					236	d. Date of del Month	ivery Day	Year
0	P.O.	that the de ad by the a detached t	ysic	1 ☐ Yes 21 9 ☐ Unknown		4∐Pregna 9☐ Unknov	nt at time of own	death 5L	Other (sp	эөсrfy)						,	
Reynold			by Ph	Part II. Other signi	ficant conditions	contributing to dea	ath but not re	sulting in the u	nderlying o	cause give	n in Part I.		23e. Did to	bacco use	contribute to	the cause	of death?
5	rds	v r-quires been sign shruld be											1 □ Y	es 2년	No 3□P	obabiy 4	□Unknown
(2)	ecords,	e law r- has bei je 2 shr	Completed										24a. Was a		24b. Were au	topsy findin	gs available
(0	$\mathbf{\alpha}$		Com										perfor	med? 2 No	death?		cause of
5	Vital	Physician: The this certificate ral director, pag	Be	25. Was case reference examiner?		Hospital:					26. Place of De	eath (C	heck only o	ne)			
5	of	<u>a</u> = <u>a</u>	٠ <u>.</u>	1 ☐ Yes 2 ☑ 27. Ma r of Deat		1 L In		ER/Outpatien			41 Nursing	,	5 Resid			cify)	
11.1	on	Attending Ph r death ector: After th by the funeral	t on:	Natural 2 Accident	5 ☐ Pendin investigatio	28a. Date of (Month	Day Year)	Injury	м	28c. Injury Work 1 □ 1	es 2 □ No	200	. Describe n	Ow IIIJury C	ccurred		
	Division	or Attend after death Director:	ertificat	3 Suicide	6 Could not be	28e. Place o	of Injury - At h	nome, farm, str	eet, factor			28f.			lumber or Ri	iral Route N	umber,
	ā	tel or A	Cert	4 [] Nomicide		bullain	g, etc. (Speci	rry)					City or Tow	n, State)			
		To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one)	1 ☑ Certifying Pl 2 ☐ Medical Exa	hysician: To the t miner: On the bas and manne	sis of examina	owledge, death ation and/or in	occurred vestigation	at the tim	e, date and place inion, death occ	ce, and curred a	due to the dat the time, d	ause(s) and pl	d manner as ace, and due	stated. to the caus	e(s)
		To the within 2 To the complet	M	29b. Signature and	(290	c. License					signed (Mont		
	7				Mr Now			ATESAN		Do.	51359			Mare	W24	h 200	8
					ress of person who					1 340	100				-		
		Sta	to		S. DIVISI	UN 3/ PA	S AUS gistrar's Sign	ature A	10(0218	104,	-					
	A ST	Registr		31. Date filed (Mon	AR 3 1 200	18	was D	ature	the s								

			For State Registrar	State of	Maryland		artment rtificate			and Me		giene (. Reg. No.	2008		209
			1. Decedent's Name (First, Middle								2. Date of De Month	ath Day	Year		of Death
	Physici /Medi		Ellan R. Reyn	es						1	March :	21, 2	2008	9:00	PM M
	Examir	ier	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location							of Death			County of Dea		
			Ginger Cove 5. Social Security Number	0.000	A == (l=	-4 5 inth d-1 A	Annap		S If Under:	24 Hrs.	8. Date of Bir		ine Aru		-
	Funeral Director		062-01-1956	6. Sex 7.	. Age (In yrs. Ia 90	Yrs.		Days	Hours	Min.	(Month, Da	ay, Year)	_ 0	rthplace (State Country)	e or Foreign
			Usual Residence of Decedent		70					þ	une 6,	, 191	/ Ne	w York	
	how at	_	10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside	
	e Ma-f s tiffied	çç	MD Anne A	rundel		Anna	polis								es 2 No
	vith th	Dire	10e. Street and Number 4000 River Cre	scent Driv	0		10f. Zip C	ode	21/0	١1		10g. Citiz	zen of What C	country?	
	s 23a	eral		12. Was Decede		10.5	Mos Doods	nt of Like	2140		i6. Vac as \$1	. 14	USA	erican Indian,	
	item item	Ë	11. Marital Status 1 □ Never Married 2 □ Marr	Armed Force	es?	. 13.	If Yes, specif	y Cubar	n, Mexican	n, Puerto R	ify Yes or No ican, etc.)		Black, Wh	ite, etc.	
920	urs al al", or Exam	by	3 Widowed 4 □ Divorced	ied 1 ☐ Yes 2 If Yes, Give Year or Date	es:		1 ☐ Yes 2	Ŭ No	Specify:				Specify: W h	ite	
2-0	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	Completed by Funeral Director	15. Deceden	t's Education			dent's Usual kind of work			t of workin	7	16b. Kir	nd of Busines:	s/Industry	
2	ithin ithin le.	ם	Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT use	retired)	ing most	or worten	9				
121	lled w lygiel her tl		17. Father's Name (First, Middle,				wrı	ter_	10 Motho	r'o Nama	First, Middle,	Maidan		Lancing	
Maryland 21215-0036	d be f antal h ed ot	Be C	Eugene Joseph								et Mac				
IZ.	should nd Me mark matic	မှ	19a. Informant's Name/Relations	hip (Type. Print)	Ī	19b. Mailir	ng Address (S	Street a					Town, State.	Zip Code)	
Z	nd 2 salth ar 27 ls 27 ls r trau		Margaret Lee/d			805	St. Ch	ris	tophe	r Ro	ad Ric	hmond	1, VA @	#@@¢	
re,	ss 1 a of Hea item othe		20a. Method of Disposition			ace of Dispo	sition (Name	of er place	9)	Da	ite	20c. Loc	cation - City o	r Town, State	
Ē	Page nent c		1 ☐ Burial 2 ☐ Cremation 4 ☑ Donation 5 ☐ Other (S		ate	,,									
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparatinent of Health and Mental Hygiene. Importants: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Royald	License	rector	22 S1	2. Name and	Addres	s of Facilit	y oard	655 W.	Ra1	timore	Street	-
_	20 E 20		11/hung	111	<u> </u>	P:	ltimo:	re,	MD	21201				,	
			23a. Fart1. Enter the dise se or hock, or heart failur. List	only one cause on each	ised the death. th line.		-					rrest,		Approxim Interval B Onset an	iate letween d Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a.		luod	enal	C	ano	cev				70	105.
1	/Medical Examiner		, southing in douting	Due to (or	as a conseque	ence of):								'	
	W. Commen	e.	Sequentially list conditions,	b. Due to (or	as a consedint	inchi (af):									
	uted d ansit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events												
ó	an an rial-tr	Exa	resulting in death) Last	Due to (or	as a conseque	ence of):					· · ·				
8760,	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	dical		d											
99	ertifica ing ph e as t	Med	IF FEMALE:	T											
Вох	death certific attending pl	Physician/Me	23b. Was decedent pregnant in the past 12 months?		h 2∐Fetalo	déath 3[Ectopic pre					23d. Date of delivery Month Day			Year
0	he de the a	ysic	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	4⊟Pregnar 9□Unknow	nt at time of dea n	atn 5∟	Other (spec	city)					Month Day Year		
P.O.	uires that the de signed by the a id be detached f		Part II. Other significant condition	ons contributing to deal	th but not result	ting in the u	nderlying cau	se give	n in Part I.		23e. Did t	obacco us	se contribute	to the cause o	f death?
Records,	quires n sign lld be	d by									1 🗆	Yes 2	2 No 3□ I	robably 4 [Unknown
00	≥ 0 0	Sete									24a. Was		24b. Were	autopsy finding	s available
Ä	yslcian: The law is certificate has b director, page 2 sl	Completed			-						auto perfo	psy ormed? 2 XNo	death?		cause of
Vital	i lcian: Th certificate ector, pag	Be C	25. Was case referred to medical examiner?						26. Place	of Death	Check only	-			
or V	Physician: this certificatal director,	70	1 ☐ Yes 2 No	Hospital: 1 ☐ Inp	oatient 2 ☐ E	R/Outpatier	t 3□ DOA	Othe	r: 4 Nu	rsing Hom	e 5□Resi	dence 6	☐Other (Sp	ecify)	
	ing P		27. Manner of Death 1 Natural 5 □ Pendin	9	Injury 2 Day Year)	28b. Time o Injury		. Injury Work			3d. Describe	how injury	occurred		
isic	Attending r death. ector: After by the funer	icati	2 Accident investig	not be 28e Place of	f injury - At hom	ao farm etr	M eat factory		'es 2 □ l		of Logation /	Street and	d Number er l	Rural Route No	umbor
Division	lor A after Direct	Certification:	4 ☐ Homicide determ	ined 200. Tace of building	, etc. (Specify)	ie, iaitii, sii	eet, lactory, t	onice		20	City or To	wn, State))	nurai noute ivi	aniber,
	spita lours neral r filled		29a. Certifier 1 ★ Certifyin	g Physician: To the b	est of my know	ledge, deat	h occurred at	the tim	e, date an	d place, a	nd due to the	cause(s)	and manner	as stated.	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only 2 Medical one)	Examiner: On the bas and manne	is of examination	on and/or in	vestigation, i	n my op	oinion, dea	th occurre	d at the time,	date and	place, and de	ue to the cause	e(s)
	To the within To the Comp	Me	29b. Signature and title of certifie	.0.			29c. l	icense	number	00		29d. Date	e signed (Mor	nth, Day, Year,)
			> 7 Flor	uy uo				1	48	28		3,	126/2	7008	
			Charles 5	who completed cause	of death (Item 2	23a) (Type,	Print)	300	+1101	0	1 0	A 1 A =	0000	, Md.	21401
			31. Date filed (Month, Day, Year)	CELONICK 300Ben	jistrar's Signatu	7. 4(JU 1.	JRT	1 Jack	K 150	1. 17	VIVICE	hour	, md.	61-101
	Sta Registr		MAR 3 1	2008	parara a alyriati	Los	will.								

Registrar DHMH 17 Rev 1/2001

		arylan show	5	10a. State	10b. County		10c. Ci	ty, Town	or Location					
		permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Medical Evaniner must be notified at once.	Director	MARYLAND	N/A			BA	LTIMO					1
				10e. Street and Nu	mber			10f. Zip Code					10g. Cit	
Ħ		ath w	<u>ra</u>	5415 1	FAIRLAWN	AVENUE				212				U
- ਰੰ		r det	Funeral	11. Marital Status		12. Was Deced Armed Ford	es?	.S.	13. Was De If Yes,	ecedent of specify Cub	Hispanic an, Mex	Origin? (acan, Puer	Specify Yes or rto Rican, etc.	No-
:48	36	s afte	by F		ied 2 Married	1 □Yes 2			1 □ Ye	s 2)(No	Spec	ify:		
7:6	5-0036	hour tural		3 Widowed		Year or Dat	es:	160	Danadant's I	Inval Ocean				16h K
	15. Decedent's Education (Specify only highest grade completed)							loa.	Decedent's \ (Give kind of life. DO NO	work done	durina n	nost of wo	orking	16b. K
2008	12	withi iene. thar	Completed	Elementary/Second	_ ' ' '	College (1-4	lor 5+)	NI	JRSING			т		HE
20	D	filed Hyg other ent, I	Be C	17. Father's Name		t)		1 140	JIIDING		1		me (First, Mid	
•	altimore, Maryland 2121	lid be fenta rked tic ev	To B	BENJAM:	IN SIMMON	IS					I	NEZ :	BROWN	
25	ar.	shour ind N mar	-	19a. Informant's N				19b.	Mailing Add	ess (Stree	,		Rural Route No	ımber, City o
E	Ξ	1 and 2 Health a tem 27 is		Geraldine	- B. Simm	nons/Wife	1	54	415 Fa	irlaw	n Av	е	Baltimo	ore. M
MARCH	ē,	item		20a. Method of Dis	position		20b.	Place of	Disposition (Name of			Date	20c. Lo
Σ	Ë	Page nent c nt: If ry or			☐ Cremation 3 [5 ☐ Other (Speci	☐ Removal from St fv)	ate		JS MEM			103-	31-08	BALT
	äĦ	permit. Pages 1 Department of Inportant: If ite any injury or of		21. Signature of Fu			1 232	DOL					MMUNIT	
	m	perm Depa Impo any i		Dar	bara C	Dion	n		1206	W NO	BROW RTH	AVEN	MMONII. UE	L FUNE
				23a. Part 1. Enter t	he disease, or con	nplications that cau	used the dear	th. Don	ot enter the i	mode of dy	ing, such	as cardia	ac or respirato	ry arrest,
4.		Physician		Immediate Cause	(Final									
		/Medical		disease or condition resulting in death)	m		L CANC		f):					
		Examiner												
	7	D +	ner	Sequentially list con if any, leading to im	nditions, mediate	Due to (o	r as a consec	juence o	f):					
	V	cuter nd ransi	Examiner	cause. Enter Unde Cause (Disease of that initiated events resulting in death)	injury	с								
	ó	e exe lan a urial-1	Ä	resulting in death) I	Last	Due to (or	r as a consec	uence o	f):					
	376	ate b hysic the bu	lica			d								
S	Box 68760,	an: The law requires that the death certificate be executed rtificate has been signed by the attending physician and for, page 2 should be detached for use as the burial-transit	by Physician/Medical	IF FEMALE:										
S S	9	ath or ttend or usi	an/	23b. Was deceden			th 2 🗆 Feta	al death	3 ☐ Ectop	ic pregnan	су			
SIMMONS	0	e de the a	sici	1 □Yes 2 □ 9 □ Unknown	□No	4 ☐ Pregna 9 ☐ Unknov	int at time of	death	5 Other	(specify) _				-
S	P.O.	uires that the de signed by the a id be detached f	Phy	Part II. Other signif		contributing to dog	th but not rec	ultina in	the condense		uon in Da	I	220 [id tobacco u
$\mathbf{R}\mathbf{I}$	S,	res th	ρ	Fart II. Other signii	ilcant conditions	contributing to dea	tii but not res	ulung in	trie underlyir	ig cause gr	veri iri Pa	IT I.		
ROBERT	tal Records,	w requir s been s should	Completed	ļ -			<u>-</u>						'	☐Yes 2
80	ec	law nasb	ple										a	vas an utopsy
	<u>=</u>	lan: The law prtificate has b	S											erformed? s 2 K No
		clan; ertific	Be	25. Was case refer examiner?	red to medical				_			ace of De	eath (Check or	ly one)
	7	hysi this c		1 ☐ Yes 2 🔀		Hospital: 1 ☐ Inj	patient 2	_		DOA		Nursing	Home 5 ☐ F	lesidence
	Ē	Ing P	.: 0	27. Manner of Deat 1 Natural	h 5 ☐ Pending	28a. Date of (Month)	Injury , <i>Day, Year)</i>	28b. Ti	jury	28c. Inju Wo	ry at rk?		28d. Descri	be how injur
	sio	tend eath. ior: / the fi	cati	2 Accident 3 Suicide	investigation 6 □ Could not b			-8	М		Yes 2	□No		
	Division of V	or At fter d direct in by	Certification: To	4 ☐ Homicide	determined	Zoe. Flace U	f Injury - At h j, etc. <i>(Speci</i>	ome, farı fy)	m, street, fac	tory, office			28f. Location	n (Street ar Town, State
		urs a	ပ္			1							4	
		To the Hospital or Attending Physicii within 24 hours after death. To the Funeral Director: After this cer completely filled in by the funeral direct	Medical	29a. Certifier (Check only one)		hysician: To the b miner: On the bas	is of examina							
		the ithin the the the the the the the the the the	Mec	29b. Signature and	title of cartifier	and manne	stated.	-		29c. Licens	se numb	er		29d. Da
		F > F 0		- Ingriatoro pillo						Di	377			3/
1	•	in		00 Name ========	- /		-4 -1 - 12	- 00-1 0	Same Delete	29	5/4	->		31
		11/		30. Name and addr	ess or herson who	completed cause	or death (Itel	11 ∠3a) (.	ype, Print)					

1. Decedent's Name (First, Middle, Last)

5. Social Security Number

218-28-9067

Usual Residence of Decedent

ROBERT

4a. Facility Name (If not institution, give street and number)

STELLA MARIS HOSPICE

SIMMONS

1**X** M 2 □ F

7. Age (In yrs. last birthday)

73

Physician

/Medical

Examiner

Funeral

Director

State Registrar

TARIO MAHMOOD

2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Months Days

4b. City. Town, or Location of Death

DULANEY VALLEY

Hours

2. Date of Death

8. Date of Birth (Month, Day, Year)

APR. 12

Day

25

1934

26

Month

March

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month **Physician** Ralph W. Snowman March 26. 2008 8:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Baltimore Timonium Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 M 2 □ F 219-18-2017 83 5/18/1924 Director Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ns 23a or 28a-f show 1 ☐ Yes 2 ☐ No Director MD Harford Forest Hill 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 2001 Hialeah Court 21050 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 6 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced White natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Balto. Citv Elementary/Secondary (0-12) College (1-4or 5+) Fire Dept. Battallion Chief 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Snowman Irene Sturgeon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fred Simmons / Nephew 2001 Hialeah Court Forest Hill, Maryland 21050 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. 4/1/2008 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Towson, Maryland 21204
Ruck Towson Funeral Home, Inc. 1050 York Road Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Years disease or condition resulting in death) Coronary Artery Disease /Medical Due to (or as a consequence of): Examiner Years *Diabetes Mellitus* Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? 1☐Yes 2☐No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dementia 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed Chronic obstructive pulmonary disease 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an autopsy performed? 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: MXNursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 2 ☐ ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature-and-title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) Type, Print) 21093 2300 DULANEY VALLEY ROAD TIMONIUM MDERNESTINE WRIGHT, M.D. 31. Date filed (Month, Day, Year) 2. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

MAR 3 1 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 3

			1 - State Registrar	Ce	rtificate of I	Death	R	leg. No.				
			Decedent's Name (First, Middle, Last)				2. Date of Dea Month	th Day Yeer	3. Time of Death			
	Physicia /Medic		KUTH M SMITH				03	12 7008	12:45 PM			
	Examin	110	4a. Fecility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	001	4c. County of Dea				
			ST. MAKYS NURSING CENT	El	LEONAL	2d TOWN	rvid	ST. MARKS				
	Funeral Director		5. Social Security Number 6. Sex 7. Age 1 M 2 A F	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey	Yeer) 9. Bir	thplace (Stete or Foreign ountry) : higan			
	p.		Usual Residence of Decedent	10c. City, Town or Lo	nostino.	7		•	10d. Inside City Limits			
	be filed within 72 hours after death with the Maryland Hygiene. d other than "netural", or items 23a or 28a-f show event, the Mayleal Examinar mant be multiped at	ctor	Md CAIVERT COUNTY	BROOM	-	IAND			1 □ Yes 2रू No			
	h with the Ma 23a or 28a-f	Funeral Director	3840 FISH Hool	KDRIVE	10f. Zip Code	0615	1	10g. Citizen of What Co USA	ountry?			
	death	ner	11. Marital Status 12. Was Decedent E Armed Forces?	ver in U.S. 13.	Was Decedent of H	lispanic Origin? (Sp	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi				
0000	urs after ai', or ite	by	1 Never Married 2 Married 1 Yes, Give Year or Dates:	lo	1 □ Yes 2 No	Specify:	,	Specify: W				
<u>ဂ</u>	in 72 ho n *natur	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of work	ing	16b. Kind of Business/Industry				
7		шо	Elementary/Secondary (0-12) College (1-4or 5-	ho ho	usewife			own home				
5	Hyg Hyg other	O O	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle,	Maiden Sumame)				
Viand	should be filed at Mentai Hygi marked other matic event,	To B	Joseph Byron Haselton			Lucy Ma	ay Hacks	tedt				
Mary	2 s = a = e = e = e = e = e = e = e = e = e	-	19a. Informant's Name/Relationship (Type, Print) Irene Evans/daughter		ing Address (Street Belsches			r, City or Town, State, A 23024	Zip Code)			
a)	1 an Heal Hem 2 ther		20a. Method of Disposition 1	20b. Place of Dispo cemetery, cre-	osition (Name of matory or other place	Date	20c. Location - City or Town, State					
Баппо	permit. Pages Department of Important: If it eny injury or o		21. Signature of Funeral Price Licentary, Dire			-		Baltimore	Street			
	*		23a Pan1. Enter the disease, or complications that caused shock, or hear failure. List only one cause on each lin	the death. Do not en	altimore,	ng, such as cardiac	or respiratory an	rest,	Approximate			
١,			shock, or heart failure. List only one cause on each lin	θ.	toret	- Vine	1 >		Onset and Death			
3	Physician /Medical		disease or condition a.	EADONE of):	W 19 10	anne			Mocosy			
	Examiner		Due to (or as	realised Blice of).	20000	9			down			
Ü	p #	iner	cause. Enter Undertying	a consequence of):	vv egoci				J			
	s be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a	a consequence of):								
09/89	at A	Medical										
×	ding p	/Me	IF FEMALE: 23c. If yes, outcome	of pregnancy				23d. Date of de	Nivery			
O. BO	that the death certific ed by the attending p detached for use as t	Physician	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	/		Month Month	Day Year					
7	that the		Part II. Other significant conditions contributing to death but	at not resulting in the u	underlying cause giv	en in Part I.	23e. Did to	bacco use contribute	o the cause of death?			
SB	uires 1 sigr 1d be	d by	112	1-11-A			1□Y	es 2 No 3 ☐ F	robably 4 Unknown			
Hecords,	sician: The law requires that certificate has been signed b irector, page 2 should be dela	Completed	C.D.P.D. 'Atnal tal	related	M, DE	mented	9 24a. Was autop perfor	sy prior to rmed? death?				
Vital	an: T tificat or, pi	a	25. Was case referred to medical			26. Place of Deal			7 22 110			
>	ysicia is cer direct	0 8	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatie	nt 2 ER/Outpatie	ent 3 DOA Ott	ACC.		lence 6 Other (Sp	scify)			
n or	ng Ph Ifter th Ineral	Certification: T	27. Manner of Death 1 Manual 5 Pending 28a. Date of Injur (Month, Day	y Year) 28b. Time of Injury	Wo	y at rk? Yes 2 □ No	28d. Describe h	now injury occurred				
DIVISION	r Attendi er death. rector: A by the fu	icat	2 Accident investigation 3 Suicide 6 Could not be 28a Place of Init	ury - At home, farm, st		103 2 110	28f. Location (S	Street and Number or F	Rural Route Number,			
≥	or Attendation of a file o	ertil	4 Homicide determined building, etc	:. (Specify)	,		City or Tou	vn, State)				
	Hospita 4 hours Funeral ely fille	Medical C	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of the control one one) 1 Certifying Physician: To the best of the control one one of the certified one	examination and/or in	th occurred at the til nvestigation, in my o	me, date and place, opinion, death occur	and due to the d red at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)			
	To the within 2. To the complet	Me	29b. Signature and title of certifier	7	29c. Licens	se number		29d. Date signed (Mor	oth, Day, Year)			
	⊬≯⊢ŏ		la mal Allan	Pros 12	ND	0641	9	3-20	-08			
			30. Name and address if person who completed cause of de	eath (Item 23a) (Type	, Print)	0011	1	0 7				
			JamesPatrick Jarboe Ph	illip J. I	Bean Medi	cal Cente	r Holly	wood,MD 2	20636			
	Sta Registi		31. Date filed (Month, Day, Year) MAR 3 1 2008	ar's Signature	made							

DHMH 17 Rev 1/2001

Ernest Samuel Sedacy Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-02005 State of Maryland / Department of Health and Mental Hygiene Unk Unk Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ March 11, 2008 1520 hrs Medical Examiner Ernest Samuel Sedacy 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** Maryland General Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthday) 5. Social Security Numberink 6. Sex **Funeral** unk Min. Months Days Hours Country' Director 1 X M 2 F 67 1940 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No MD Baltimore , or items 23a or 28a-f shor must be notified at once. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1331 Division Street 21217 14. Race - American Indian, Black, unk 12. Was Decedent Ever in U.Sink 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Mantal Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Married 1 Never Married Yes Yes 2 X No specify: Specify: If Yes, Give Year black permit. Pages I and 2 should be filted within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or injury or other traumatic event, the Medical Examiner: 3 Widowed 4 Divorced ģ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done nk 15. Decedent's Education (Specify only highest grade completed) unk during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) 21215-0036 unk 18.Mother's Name (First, Middle, Maiden Sumame) unk 17. Father's Name (First, Middle, Last) unk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) O.C.M.E. 111 Penn Street Baltimore, MD 21201 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition ltimore, crematory or other place) 2 Cremation 3 Removal from State Denation 5 X Oth er Specify: ip state 21 Signature of Funeral Service Licens 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Director <u>Baltimore.</u> Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. a. Hypothermia complicated by pneumonia and acute alcohol intoxication Death /Medical Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and trar Physician/Medical AMENDED 23a, 27, 28a-f per ME g878 4/1/08 amh XX UNPENDED attending physician or use as the burial -23d. Date of delivery Box 68760 23c. If yes, outcome of pregnancy IF FEMALE: Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 1 Yes 2 No 3 Probably 4 ✔ Unknown þ ٦. Completed Records, 24b. Were autopsy findings available 24a, Was an prior to completion of cause of autopsy has performed? death? 1 🗸 Yes ✓ Yes 2 No 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical of Vital Be Other₄ Hospital: 1 Nursing Home 5 Residence 6 Other: Inpatient 2 V ER/Outpatient 3 this 1 🗸 Yes No 28d, Describe how injury occurred Subject exposed to environmental 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year 28b. Time of Injury After 27. Manner of Death 1 Yes 2 X No Natural Division Found 9:33 am 5 Pending Found 3/11/08 r death. Director: the 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1505 Futaw Place 28e. Place of Injury - At home, farm, street, factory, office building, etc. filled in by 3 Suicide 6 Could not be determined (Specify) Street Baltimore, 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number Signature and title of certifier March 12, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Patricia Aronica-Pollak MD. Assistant Medical Examiner

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

31. Date filed (Month, Day, Year)

32. Régistrar's Signature

2008

OCME

DHMH 17 Rev 1/2001

Registrar

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** March 27, 2008 Girija Nandan Singh 2:23 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Montgomery Takoma Park 8. Date of Birth (Month, Day, Dec. 4, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Hours Days 12 M 2□ F 73 Yrs 1934 Dec. 068-42-2122 **Director** India Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Director Maryland Montgomery Potomac 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 10908 Riverwood Drive 20854 India Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Asian Indian þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Physician Physical Medicine 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Not Available ပ္ Not Available 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith E. Singh/Wife 10908 Riverwood Drive, Potomac, MD 20854 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 20a. Method of Disposition $\operatorname{\mathsf{April}}^{\scriptscriptstyle\mathsf{Date}}$ 2 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 Bethesda, MD 22 Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, MD 20850 21. Signature of Funeral Service License M01346 23a. Part1. En er the disease, or complications that caused the death. shock, or heart failure. List only one cause on eac. line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 100 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed ng physician and as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending | IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No been signed by the should be detached 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an s certificate has b lirector, page 2 s perforn 2 No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 124 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 2 To the I and manner stated. 29b. Signature at of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 7610 Carroll Ave., Takoma Park, MD 20912

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32 Registrar's Signati

ANJum

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 2:45A.M. March 24, 2008 Franziska Schiffer /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 10017 Sorrel Avenue Potomac If Under 24 Hrs Montgomery . Age (In yrs. last birthday) If Under 1 Year Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2 🔀 F Months Hours Days Director 570-62-1055 77 December 31, 1930 Germany Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10017 Sorrel Avenue 20854 by Funeral <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 XNever Married 2 Married 1 ☐ Yes 2 🖾 No Specify 3 ☐ Widowed 4 ☐ Divorced "natural", White Completed 16a. Decedent's Usual Occupation the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 4 Teacher Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Eduard Schiffer Wilhelmine Hartman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10017 Sorrel Avenue, Potomac, Maryland 20854
Disposition (Name of Date 20c. Location - City or Town, State Dominique H. Schiffer/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium Inc. 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2^{March} 2008 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signature of Funeral Service Licensee Rockville, Rockville, Inc. 300 Maryland M00335 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Years Chronic Obstructive Pulmonary Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any trained to a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse juence of) Physician/Medical Examiner burial-trar and Due to (or as a consequence of) physician the as IF FEMALE use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 🗓 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has be 2 s autopsy performed? page certificate 1□ Yes 25. Was case referred to medical director Be 26. Place of Death (Check only one. examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA Certification: To this funeral 28b. Time of 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred 28c. Injury at Work? After (Month, Day Year) Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

requires that the death certificate be execut Division or Vital Records, P.O. Box 68760, or Attending Physician: ours after death. within 24 hours a

Maryland 21215-0036

Baltimore.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 ី Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1201 Seven Locks Road, #111 Rockville, Maryland 20854 William Silverman, M.D.

D0027985

March 24, 2008

State Registrar

completely

Medical

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Robert Strasbough Sr 02:28 M 29 March 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Medical Baltimore City Center Barrier If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, ADR 1/2 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) Funeral 1**9**M 2□F 84 Days Min 218-14-1037 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits ns 23a or 28a-f show must be notifled at 1 Yes 2 No Director Dundalk 10g. Citizen of What Country? 10e. Street and Number 21222 U.S.A permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s any injury or other traumatic event, the Medical Examiner must by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No WWII If Yes, Give Year or Dates: NOCA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seçondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 223 HVENUE 21222 Maoma n dalk 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location -20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3-31-08 Balhmore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Home, PA, Rd. 21222 , 110 W 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) failure 48 hours **Physician** Congestive heart /Medical Due to (or as a consequence of): Examiner 8 years Ischemic cardiomyopoth Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-transi 30 years artery Coronary Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Be Completed by Physician/Medical the attending IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐Ectopic pregnancy ō Month 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 1□Yes 2□No 9□Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Injury 1 XNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Justin Bachmann

Dustin Backmann

Begistrar's Signature

Medical Doctor

Johns Hopkins Hospital,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

RES-000

600 North Wolfe Street Bultimore,

29d. Date signed (Month, Day, Year)

March 29.

2008

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Storkins-Stachlinski March 28,2008 12:50A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gilchrist Care Center Towson Baltimore 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Funeral 1 □ M 2 🔯 Months Days Hours Min. 216-74-8376 Director 73 Oct24,1934 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at Director 1 ☐ Yes 2X No Md. Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 2520 Pot Springs Road items 23a 21093 U.S.A. death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ঐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 🖾 No Specify þ White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. Disabled Disabled 7 Is marked other traumatic event, 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Anthony Stachlinski Frances ဨ Jurkowski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 0 9 3 19a. Informant's Name/Relationship (Type. Print) 27 Department of Health Important: If Item 27 any Injury or other to once. Theresa Pac (sister) 142 Westbury Road Lutherville, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Bayview Crematory 3-29-2008 Baltimore, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility aczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee LOU 1201 Dundalk Ave. Baltimore, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Complications Wecks disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): law requires that the death certificate be executed the burial-trans resulting in death) Last Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day P.0. signed by the a 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Mentar Remonton 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has was autopsy performed? certificate 1 ☐ Yes 1 Yes 2 No Physician: 25. Was case referred to medical examiner?
1 Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending investigation death. FELL FALM STANDING ours after death. MARCH 14 2008 1 □Yes 2 No 2 Accident VMENUN 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 2520 PET SPRING UMD, LUTHENVILLE MD CROUP HAME within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2/093 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MARCH 28 2003 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

ARON 31. Date filed (Month, Day, Year) MAR 3 1 2008

J. cumies

egistrar's Signature

m

Sparte)

6701 N. Chances

		-	For State Registrar	State of Ma	ryiane	•	rtificate of			Reg. No. 2	008	1021
Phys	iciar	1	1. Decedent's Name (First, Middle, Last	*	1	اسماد مرد			2. Date of Dea Month	Day	Year	3. Time of Death
/Me	dica	I.	GEORGE 4a. Facility Name (If not institution, give		UES	11066		r Location of Deat	MARC		v of Death	1 1 Page M
Exan	nine		/	Spital "	00	Tox		DA/15/80=		14	T. nie.	re
Funer	al		Social Security Number 6. Se	7. Age	(In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	th v. Year)		place (State or Foreign
Directo	or		213-03-3787	M 2□F	93	Yrs.	months Bayo	Tiodio Willia	May 5,	1914		MD
land 5w		ŀ	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
Mary a-f sh		101	MD Balt:	imore		Randa	11stown					1 ∐Yes 2 X No
th the or 28a e noti		Director	10e. Street and Number				10f. Zip Code	-		10g. Citizen of	What Cour	ntry?
ath wi 23a ust b	1	2	3605 Briarstone I					1133		US		
er dez items ner m		runeral	11. Marital Status	12. Was Decedent E Armed Forces?		S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	pecify Yes or No- to Rican, etc.)	- 14. Ra Bla	ce - Amerio ack, White,	
urs aft	3	y	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes 2 🏹 N If Yes, Give Year or Dates:	O		1 ☐ Yes 21 No	Specify:		Speci		ite
IIIU Z I Z I 3-UU30 be filed within 72 hours after death with the Maryland the Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	3		15. Decedent's Edu (Specify only highest grad	ucation	Į	16a. Dece	dent's Usual Occup	ation	rkina	16b. Kind of E		
ithin 7 nan "u	1	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)	life.	DO NOT use retired	d)	King			
iled w lygiel	3		17. Father's Name (First, Middle, Last)				lanager	18 Mother's Nar	ne (First, Middle,			lorist
d be i	٥	o De	George Schwesinge	er					Schuett			
should and Men s marke umatic	F	2	19a. Informant's Name/Relationship (T)			19b. Mailir	ng Address (Street				n, State, Zip	c Code)
and 2 and 2 ealth a n 27 Is			Geraldine Schwesi	nger Wii	ē	3603	Stoneybr	ook Road	Randal	l1stown	, MD	21133
ges 1 of He if iten			20a. Method of Disposition 1 → Burial 2 → Cremation 3 → I	Removal from State	20b. Pl	ace of Dispo emetery, crei	sition (Name of matory or other plac	ce)	Date	20c. Location	- City or To	own, State
thent of transfer the standard of the standard of the standard of the standard of the standard or of the sta			4 ☐ Donation 5 ☐ Other (Specify,)	Dru		ge Cemet					e, MD
paritimity is wait yially ZIZIS-0050 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is anatked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	ouce		21. Signature of Funeral Service Licens	m de	n K	/ ^	2. Name and Addre Cline Fund	•		Reiste erstown		
1.71.3			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused	the death	,					, FID	Approximate
Physicia	n		Immediate Cause (Final			moa	/					Interval Between Onset and Death
/Medica	al		disease or condition resulting in death)	a. Due to or as a			· ·				-	
Examine	₩.		Sequentially list conditions,	b								
be sit	9	Examile	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Jusease or mury	Due to (or as a	consequ	ence of):						
xecut and	3	X	that initiated events resulting in death) Last	c Due to (or as a	consequ	ence of):						
tificate be executed g physician and as the burial-transit				d.								
The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	1.5	Jeancal	IF FELLING	G							4.5	
ath ce ttendir	1	SICIALIVIN	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome p 1 ☐ Live birth	2 □ Fetal	death 3	Ectopic pregnancy	y			ate of deliv	ery Day Year
the at	1.9	200	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of de	eath 5	Other (specify)				ionin'	Day Teal
that the ed by detac	ď		Part II. Other significant conditions co	ontributing to death bu	t not resu	lting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use cor	ntribute to t	he cause of death?
w requires to been signer should be	2	combiered by	DYEPHAGIA S	TATUS	205	T G	ASTROS"	Temy l	e _ 10'	Yes 2 No	3 ☐ Prol	bably 4 □Unknown
aw rec	100		AGULE PER	44 74	luce	20			24a. Was		. Were auto	opsy findings available
The I		5							autor perfo 1□ Yes	ormed?	death?	ompletion of cause of
cian; certifica	0		25. Was case referred to medical examiner?	11			Tau		ath (Check only o	one)		
Physi this o	F	2	1 Yes 2 No	Hospital: 1 Impatier 28a. Date of Injur		ER/Outpatier 28b. Time o		4 🗆 Nursing r	lome 5 Resid			fy)
ding h. After funer	1 2		1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury	Wor	yaı k? Yes 2∐No	Zod. Describe	how injury occu	irreu	
Atten r deat ector:	100	2	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of inju			eet, factory, office				ber or Run	al Route Number,
tal or safte	in the contract of the contrac		4 [Trofflicide	building, etc	. (Specify				City or Tou	wn, State)		
To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use.	Modiool			vsician: To the best of iner: On the basis of and manner sta	examinat							
To th withir To th	M	NIA.	29b. Signature and attle of certifier	1			29c. Licens	_		29d. Date sign		
			1 Offen	17 0	2)		PI	1502		MARCO	242	5, 2008 CENTER 24133
. F.			30. Name and address of person who c			~	Print)	Nonth	WEIT	Horpid	41	CENTER
10	İ		ORIANDO B. CO	NANTAN	ne	<i>U</i>	1	4204119	www.	Masyl	420	4133

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)
MAR 3 1 2008

vancy ripton		State of Maryland / Department of Health and Mental I 1-For State Certificate of Death		Reg. No	200	8 1022
Physician		Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of De	ath		3. Time of Death
Medical Examine		Nancy Ellen Tipton	Month March 2			0520 hrs
An		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dea 2721 Hanover Pike Manchester	ath	- 1	c. County of DeatCarroll	h
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24F	rs. 18 Date of B			rthplace (State or Foreign
Director		Months Days Hours M	⁄lin.		Co	ountry)
	-	215-68-0595 1 M 2XXF 50 Yrs.	March	18,	1958 Ma	ryland
any		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
and show	۱۵	Maryland Carroll Manchester				1 ∑Yes 2XXX No
Maryl.	Director	10e. Street and Number 10f. Zip Code			tizen of What Cou ted Stat	
Ba or the	֡֞֞֞֞֞֞֞֞֡֞֞֞֞֡֡֡֡֞֞֞֞֡֞֞֞֡֞֡֡֡֡֡֡	2721 Hanover Pike 21102		of	America	
2 hours after death with the Maryland "natural", or items 23a or 28a-f show Examiner must be notified at once.	uneral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Puel	Specify Yes or I rto Rican, etc.)	10-	14. Race - Ame White, etc.	rican Indian, Black,
or it	<u> - </u>	1 Yes 2 XXNo 3 Widowed 4 Divorced If Yes, Give Yeer 1 Yes 2XX No specify:			Specify: Wh	nite
urs afl tural'	핡	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of the completed)		16b.	Kind of Business	
72 ho n "na al Ex	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use r	retired)			
036 vithin ene. er tha	립	3 Licensed Practical N			ealth Ca	re
15-C	Be C	17. Father's Name (First, Middle, Last) 18.Mother's Na	me (First, Middle	, Maide	n Surname)	
212 ild be Menta marke		Richard Anthony Moore Emma 1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of	Louise (ear	V Čity or Town Stat	te Zin Code)
AD 2 shou n and 1 is r matic	- 1	Ricky Allen Tipton (Husband) 2721 Hanover Pike, N				
Baltimore, MD 21215-0036 permit, Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c	. Location - City o	
TOF Pages ent of nnt: If			April l, 2008		atonsvil	le, Maryland
altir mit. I partm ports ury o	5	21. Signature of Funeral Service Licensee 22. Name and Address of Facility E	ckhardt	Fun	eral Cha	pel, P.A.
		Som (Symum) 3296 Charmil Driv	ve, Mano	hes	ter, Mar	yland 21102
Physician /Medical	V	3a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia failure. List only one cause on each line.				Approximate Interval Between Onset and
Fxaminer		Immediate Cause (Final disease of condition resulting in death) Atherosclerotic Condition resulting in death)	ardiova	scul	ar Disea	ise Death
		b				
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Cause. Enter Underlying Cause				
/	٤	Cities or injury that initiated events resulting in death) Last Use to (or as a consequence of):				1
ruted md transit	֪֜֞֜֞֜֞֜֞֜֞֜֜֞֜֜֞֜֜֞֜֜֡֡֡֡	d				
be exe ician	Medical	MUNPENDED AMENDED 23a, 27, 28a-f per ME g878 4/2/08 amh anend items 23a, pt TT 28a-f, 27 per me g8 IF FEMALE: 23c. If yes, outcome of pregnancy	79 / <u>-</u> 11-0	Q vet		
760 ficate g phys	ğ [23h Mac decedent progrant in the		2	3d. Date of delive	ery Day Year
x 68 h certi endin use a	اع اع	past 12 months? 4 Pregnant at time of death 5 Other (Specify)	gnancy		MOTHET	Day Year
Bo e deat the att	ᇍ	1 Yes 2 No 9 Unknown 9 Unknown				
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Asthma, Chronic Alcoholism				o the cause of death? obably 4 V Unknown
S, F luires an sign		Tablini, official Actionism	_			autopsy findings available
Ord aw rec nas bee	ompleted		au	opsy formed	prior to	completion of cause of
Rec The The licate licate	5		1 ✔ Ye	3 2		
ital ician: s certii	Re	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other4 Nur	rsing Home 5	Dooi	dence 6 🗸 Oth	or Coops
of V ; Phys rer thi	유	1 ✓ Yes 2 No Prospite 1 Inpatient 2 ER/Outpatient 3 DOA One 4 Nur 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?			njury occurred	er. Scerie
on on anding ash.	틸	1 Natural 5 Pending (Month, Day, Yeer) 1 Yes 2 No	77.1			
viSic or Atte her der hirecto n by t	⊒	2 Accident Investigation 3 Suicide SX Could not be 1 Accident Investigation Suicide SX Could not be	28f. Location	(Street	and Number or F	Rural Route Number, City
Division Division Division Diplication Division Director: y filled in by the	Certification:	4 Homicide determined (Specify) Found: Residence			Carroll C	
e Hos 124 hu e Fun letely		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a	and due to the ca	use(s)	and manner as sta	ated.
To the He within 24 completel	ᄝ	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated. 29b. Signature and title of certifier 29c. License number	— — Ime ume, da		d. Date signed (M	
	2			- 1	arch 26, 2008	
	ļ	100 100 1		1416		
		30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201				
Stal	-	31. Date filed (Month, Day, Year) 32. registrar's Signature				
Registra	ar	MAR 3 1 2008 1000 A				
DHMH 17 Rev 1/200	1	ORIGINAL			=	

DHMH 17 Rev 1/2001

Registrar

2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 24, 2008 P^{M} 1:00 March Lawrence Carter Utterback /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Brooke Grove Rehabilitation & Nursing Center Sandy Spring Montgomery If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1X M 2 □ F 577-44-4381 February 3, 1933 Washington, D.C. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Director Rockville Maryland Montgomery 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 4721 Wyaconda Road 20852 <u>United States</u> 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates:1953 – 1955 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 2 Specify: 3 ☐ Widowed 4 X Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Photo Engraver 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cathryn McCullough Benjamin Utterback 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7925 Coriander Drive d*104 Gaithersburg, Maryland 20879 Lawrence C. Utterback/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State March 28, 2008 y's Cemetery 28, 2008 Rockville, Maryland
22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Rockville, Inc. 300 West Montgomery Avenue
Rockville, Maryland 20850-2805 4 ☐ Donation 5 ☐ Other (Specify) Mary's Cemetery 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lie only one cause on each line. Immediate Cause (Final **Physician** 9 Years disease or condition resulting in death) <u>Advanced Cancer of Throat</u> /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine be executed burial-transi and resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Year 4□Pregnant at time of death 5 ☐ Other (specify) 1□Yes 2□No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. þ 1X Yes 2 No 3 Probably 4 Unknown Diabetes Mellitus, Deep Venous Thrombosis of Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Upper Limbs, Failure to Thrive, Malnutrition autopsy performed 2 💢 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2K No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Shyamsundar Rajan, M.D.

31. Date filed (Month, Day, Year)

D53367

9801 Georgia Avenue, Suite 117, Silver Spring, Maryland 20902.

March 25, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 2008 1316 22, March Kalidas L. Vaidya /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Burtonsville <u>3504 Loma Linda Court</u> If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Days Min **Funeral** Months Hours 1X M 2□ F India 05-20-1922 85 Director 215-29-3064 Usual Residence of Decedent 10d. Inside City Limits e tiled within 72 hours after death with the Maryland al Hygiene. other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10b. County or 28a-f show o notified at 10a. State 1 ☐ Yes 2 No Burtonsville Director Montgomery Maryland 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number "natural", or items 23a or United States 20866 3504 LomaLinda Court Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 207 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify þ 3 ☐ Widowed 4 ☐ Divorced Asian Indian 16a. Decedent's Usual Occupation 16b Kind of Business/Industry Completed Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) India Government Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event Be Nathiben Vaidya Lallubhai Vaidya 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3504 Loma Linda Court Burtonsville, Maryland 20866 Harish Vaidya / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Arundel Crematory 03-25-2008 Odenton, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.
1411 Annapolis Road Odenton, Maryland 21113 21. Signature of Funeral Service Licenses manta Rthomas 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1/2 years **Physician** Lung Cancer /Medical Due to (or as a consequence of): Examiner years Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-tran Due to (or as a consequence of): physician Physician/Medical the as IF FEMALE 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery use 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No for signed by the a d be detached for 9☐Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page 2 s performed 2**X** No 1∐ Yes certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 1 Inpatient P this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death After t Certification: Hospital or Attending 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Aft М investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3☐ Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 M.D. D43430 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar Gaurang Thaker, M.D.

Day,

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Records,

Division or Vital

32. Registrar's Signature

3411 Olandwood Court, #105 Olney, Maryland 20832

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No._ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year Year 25 2008 **Physician** Evelyn, Vociker /Medical Johns Hopkins Bayvier Medical Center 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltmore 5. Social Security Number 6. Sex 8. Date of Birth (Mgnth, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 M 2 1 F 212-28-645 Usual Residence of Decedent Director 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits items 23a or 28a-f show ner must be notified at 1 ☑Yes 2 ☐ No Baltimox Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21222 1725 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Maryland 21215-0036 r than "natural", or the Medical Exami Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) artment of Health and Mental Hyg ortant: If item 27 is marked other Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnam Be Pages 1 and 2 should be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Department of Important: If any Injury or once, 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 2134 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Respirator **Physician** Lywod 4 Failure /Medical Due to (or as a consequent of): Examiner Pleural Effusions 2 weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of): The law requires that the death certificate be executed the burial-transit Myelodysplastic
Dué to (or as a consequence of): syndrome unknown and Box 68760 physician Physician/Medical IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4□Pregnant at time of death P.O. 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 | Yes 2 | No 3 | Probably 4 X Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy death? 2 **X**No Division or Vital 1∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 No Certification: To 1 htpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 24 hours after death. Injury 1 Natural 5 Pending To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier (Check only one) 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 1/2001

32, Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bayview 4940 Eastern Avenue JESSICA Savage MD Johns Hopkins Bayview 4940 Eastern Avenue Baytimore MD 21224

UMP P19643

29d. Date signed (Month, Day, Year)

march 25,2008

		1 - For State Registrar	State o	of Maryland		artment o			ind M	-	giene Reg. No.	008	102	25
Physic /Medi		1. Decedent's Name (First, Middle, Genevieve	М.	Varg	ţа					2. Date of De March	28°,	2008	3. Time of 3:30	
Examir Funeral	ner	4a. Facility Name (If not institution, Future Care (5. Social Security Number	Canton Canton		ast birthday)	4b. City, Tov Balt	imo	re Under 2	Cit			unty of Death	olace (State o	r Foreign
Director		215-09-5246 Usual Residence of Decedent 10a. State 10b. County	1□M 2∰F	88	Yrs.		lays F	Hours	Min.	Dec 18	year, 191		yland 10d. Inside Cit	h. Limita
ore, Mary Idilio Z IZ I 3-0030 ss 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Manall Hygiene. If the still hand Manall Hygiene. I marked other than "natural, or iteme 28s or 28s-f show it other treumatic event, the Medical Examinar must be notified at	Funeral Director	Md. 10e. Street and Number 717 South Cur	lev St	Ва		ore Ci	de					of What Cou	12 Yes	•
	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	12. Was Dec	edent Ever in U.Sorces?		1 □ Yes 2 🖸	Kno s	Specify:	jin? (Spe , Puerto F	cify Yes or No Rican, etc.)		Race - Amen Black, White, ecify: Wh		
	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 1 2 th 17. Father's Name (First, Middle, L	grade completed) College ((Give life.	dent's Usual O kind of work o DO NOT use r ales	lone durir etired)	ng most		ng (First, Middle,	Reta		dustry	
	To Be	John Kreczme	er		19b. Mailir	ng Address (Si		Agn	es	Majka			o Code)	
		Sheila Kaszal		20b. PI	ace of Dispo	Fulbi	of	Ro		Baltir Baltir		Md • 2 on - City or T		
Daltillore, permit. Pages 1 an Department of Heal important: if item 2 eny injury or other		1 Purial 2 Cremation 3 4 Donation 5 Other (Spa	ecify)		ered H	eart of 2. Name and A	E Jes	f Facility	acz	orowsl	ki Fu	neral		,PA
Physician		23a. Part1. Enter the disease, or or shock, or heart failure. List o Immediate Cause (Final disease or condition	nly one cause on	caused the death each line.	. Do not ent	er the mode of	f dying, s		cardiac o	. Bali		e, Md	Approximate Interval Bett Onset and D	ween
w requires that the death certificate be executed xx been signed by the ettending physicien and should be detached for use as the burial-transit as	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to	(or as a consequi	ence of):									
the death certification of the ettending of the ettending of the ettending of the ettending of the ettending of the ettending of the ettending of the ettending of the ettending of the ettending of the ethen eth	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ◯ No 9 □ Unknown	1 ☐ Live I	tcome of pregnar birth 2 Tetal nant at time of de lown	death 3[Ectopic pregr Other (specif					23d.	Date of deliv Month	-	'ear
equires that en signed b	Ď	Part II. Other significant condition	s contributing to d	leath but not resu	lting in the u	nderlying caus	e given ir	n Part I.			obacco use d Yes 2□N		he cause of d	eath? Inknown
vicion: The law r certificete has be rector, page 2 sh	Completed									24a. Was autor perfo 1 🗆 Yes	osy imed?	4b. Were auto prior to co death? 1 Yes	opsy findings a empletion of ca 2 \(\text{No} \)	available ause of
ng Phys fler this	ation: To Be	25. Was case referred to medical examiner? 1 Yes No 27. Manner of Death 1 Natural 5 Pending investiga	28a. Date (Mon		ER/Outpatier 28b. Time of Injury	nt 3□ DOA f 28c.	Other: Injury at Work?	4 Our	sing Hon	Check only one 5 Resident Resi	dence 6 🗆		(y)	
To the Hospitel or Attendi within 24 hours after death. To the Funarel Director: A completely filled in by the t.	Certification:	3 Suicide 6 Could no 4 Homicide determin	ed 286. Place build	of Injury - At hor ling, etc. (Specify,)					Bf. Location (City or To	wn, State)			ber,
the Hosp ithin 24 hosp the Fune empletely fi	Medical	29a. Certifier (Check only one) 2 Medical E	Physician: To the caminer: On the b and man	e best of my knov pasis of examinati iner stated.	vledge, death on and/or in	vestigation, in	my opinio	on, death	d place, a h occurre	ed at the time,	date and pla	d manner as s ce, and due t gned (Month,	o the cause(s)
F≯Fŏ	1	Muymani Muli 30. Name and address of person w		se of death (Itam	23a) (Type	D	476		•		3/28			
Sta Registr		Raymond Miller 25 31. Date filed (Month, Day, Year)		Registrar's Signat			ns nos h	9₩A	MP	2113	6		-	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Itemstaza of Maryland 8790 at 1991 yold may the and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Рм **Physician** 23 James Brian Wah 2008 March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 621 Walker Avenue

5 Social Security Number 6. Sex Baltimore Baltimore
If Under Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 03-22-1964 7. Age (In yrs. last birthday) Social Security Number **Funeral** Hours Months Days 1**X** M 2□ F 44 216-80-8074 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County show an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at 1 ☐ Yes 2X No Director MD Baltimore Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 621 Walker Avenue 21212 USA and 2 should be filed within 72 hours after death lealth and Mental Hygiene. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify: Asian 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) h and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 12 Restaurant Manager Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Wah 2 Helen L. Seebach 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Helen L. Parker/Mother 9220 West Meadow Hills Drive, Sun City, AZ 85351 other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Department of H Important: If Ite any Injury or ot once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rémoval from State Woodlawn, Maryland 3-31-2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature Fundal ervice Licensee 1050 York Road, Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Selfinflicted Immediate Cause (Final GunShot wound to chest **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of): attending phystcian for use as the buria Division or Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ▼No 24a. Was an certificate has b irector, page 2 s autopsy performe funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Yes 2□ No this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After t Injury 1 Natural 5 ☐ Pending investigation March23,2008 14 H 7 M 15

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) death. 1 TYes To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A qunshotwound 2 Accident 28f. Location (Street and Number or Rural Route Number of Rural Ro 6 ☐ Could not be 3 Suicide 4 ☐ Homicide Baltimore Home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

Registrar

31. Date filed (Month, Day, Year) 2008

6 Trimb 32. Registrar's Signatur

who completed cause of hath (Item (3a) (Type, Print)

e Hill CT. Lytherville

March 24,2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg No 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Month March 29 Bertha Weller 2008 7:30 am^M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Ivy Hall Geriatric Center Middle River Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 □ M 2 🗓 F Months Days Hours 216-16-2761 84 2/1/1924 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Marvland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 207 Brett Court Apt 207 21221 U. S. A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? 1 Never Married 2 Married 1 ☐Yes 2 XNo If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced Specify White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herman Vragel Edna Kosman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Stratmeyer (Daughter) 2405 Gilwood Drive Joppa, Maryland 21085 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State /31 4 ☐ Donation 5 ☐ Other (Specify) 2008 Bayview Crematory Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue PA Essex, Maryland 21221 23a. Part1. Enter the disease, or compleations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3. Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an

Physician /Medical Examiner

permit. Pages
Department of
Important: If it
any Injury or o

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be ပ

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ment of Health and Mental Hygiene. mit: If term 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Mexical Exprint contrast to a cuffied at any or other traumatic event, the Mexical Exprint contrast to a cuffied at

Baltimore, Maryland 21215-0036

r than "natural", or items 23a or 28a-f shov the Medical Examinar must be rediffed at

Examiner burial-transi attending physician for use as the burial Physician/Medical ed by the a detached f signed by t I be detach \$ s been si should I Completed page 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be Certification: To

Medical

has

certificate !

law requires that the death certificate be executed

Records, P.O. Box 68760,

Division of Vital

IF FEMALE: 9 Unknown 25. Was case referred to medical 1 ∐Yes 2 🛣No

27. Manner of Death

2 ☐ Accident

4 Homicide

3 ☐ Suicide

2 XNo 1 ☐ Yes 2 ☐ No 1 ☐ Yes

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

29d. Date signed (Month,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

5 ☐ Pending investigation

6 ☐ Could not be

determined

28a. Date of Injury (Month, Day, Year)

Oh

br John

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

32. Segistrar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year A M ZEOB Thomas Ε. Wilkinson, Sr. Z-7 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Glen Burnie Baltimore-Washington Medical Center 9. Birthplace (State or Foreign Country) New York If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year July 3, 19 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Days Hours 1 ★ M 2 🗆 F Months 78 1929 100-20-9886 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County 1 □Yes XXNo Anne Arundel Millersville Maryland | 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21108 467 Brightwood Road 12. Was Decedent Ever in U.S. Armed Forces? 1951- Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Specify: White 1952 1 ☐ Yes 2 ☑ No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Graphic Arts Printer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret O'Dwyer Thomas N. Wilkinson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 467 Brightwood Road Millersville, MD 21108 Jeanette Wilkinson / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Durial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, MD Crownsville MD Vet. Cem. 22. Name and Address of Facility Kirkley-Ruddick Funeral Home P.A. MD 21061 421 Crain Hwy. S.E. Glen Burnie, MD 21061 21. Signature of Fun rat Service Dicense 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) orgestive Due to (or a a consequence of): Fibrilatia Atrial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ⚠ No 24a. Was an autopsy performed? 1 Yes 2 ANO 2 No 25. Was case referred to medical 26. Place of Death (Check only one) fy)

Examiner Box 68760, certificate be Ö ٦. or Vital Records,

Physician

/Medical

Physician

/Medical

Examiner

Director

Funeral

ģ

Completed

Be

၉

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; if flear 27 is marked other than "natural". The marked other than "natural".

ed by the attending p detached for use as signed by t

Physician/Medical þ Completed Be ို

Certification:

Medical

Examiner

filled in by the funeral

Hospital or Attending Physician:

Division

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient	3□ DOA	Other: 4 Nursing H	lome 5 ☐ Residenc	e 6 □Other (Speci
Manner of eath	28a. Date of Injury	28b. Time of	28c.	Injury at	28d. Describe how i	njury occurred

1 Natural 2 Accident 5 ☐ Pending investigation 6 ☐ Could not be 3 ☐ Suicide

29b. Signature and title of certifier

4 ☐ Homicide

(Month, Day Year) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

MARCH 27, 2008

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year)

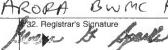
30. Name and address of person who completed cause of wath (Item 23a) (Type, Print) HOSPITAL 301 HOSPITAL DR GLNBURNIEMD BWMC

D006/219

State Registrar

17

HARVIN DER 31. Date filed (Month, Day, Year) MAR 3 2008



DHMH 17 Rev 1/2001

within 24 hours a

To the Funeral C

completely filled i

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2008 10:15 AM /Medical 4e. Facility Name (If not institution, give street and number)

BLADFORD DAKS NWSING HOME

5. Social Security Number

6. Sex 7. Age (In yrs. last bint) 4c. County of Deeth 4b. City, Town, or Location of Death Examiner 20734 rince George ON MD II Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 💢 F 609 Director Usual Residence of Deceden 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28a-f show 1 ☐ Yes 2 X No Director Prince George's Clinton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20735 USA 7520 Surratts Road Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Pages 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiene. Int: If Item 27 te marked other than "natural", or Ite 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) unk unk Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry Warrington Bessie Coy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine Kohne/daughter 6007 Bobcat Court Waldorf, MD 20603 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. * 4 Donation 5 Other (Specify) Signature of Fund Service Licenses State Anatomy Board 655 W. Baltimore Street Director Part 1. Enter the disease, of complications that caused the death. shock, or heart failure. List only one cause on each line. Baltimore, MD 21201 Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) the attending physician ned for use as the burial P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel dea
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetel death 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2 No 9 Unknown Part II. Ot er significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 🗌 Yes 2 **X**No 3 Probably Completed been 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s this certificate To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpalient 3 DOA Other: Certification: To 1 ☐ Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier License number of person who completed cause of death (Item 23a) (Type, Print) 30-Name an NO.0. 70 1109 i 2 Registrar's Signature 31. Date liled (Month, Day, Year) 32. 2008 Registrar

			Please	Type or Print	in Black Inc	delible Ink	. Ensure A	I Copies	s Are	Legible.			
			_ For	State of Man	yland / Depa	artment of I	Health and M	1ental Hy	/giene	9			
			T = For State Registrar		Cei	rtificate of	Death		Reg. No	.2008	102	231	
7	Dhyaiai	1	1. Decedent's Name (First, Middle, Las	st)				2. Date of Do	eath Da	y Year	3. Time of E	Death	
	Physici /Medic		Robert	L. Wamsle	У			March	28,	2008	9:30	A^{M}	
	Examir		4a. Facility Name (If not institution, give				or Location of Death		4c.	. County of Death			
			199 Rollins Aven				ville			Montgome			
1	Funeral Director		5//-36-2429	ex 7. Age (/ M 2□F 78	n yrs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Bi (Month, D February	rth lay, Year) 7 23,	9. Birthp Cour Washir	lace (State or stry) ngton, D.	· C.	
	iges 1 and 2 should be filed within 72 hours after death with the Maryland not Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	_	Usual Residence of Decedent 10a. State 10b. County		Oc. City, Town or Lo					1	0d. Inside City		
	Ba-f s	Funeral Director	Maryland Montgome	ery	Rocky	ville						20140	
	ith th	Dir	10e. Street and Number	"		10f. Zip Code				tizen of What Cour			
	ath w	ral	199 Rollins Aven				1852			ited Stat			
	er de Items	nue	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13. \	Was Decedent of If Yes, specify Cul	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or N Rican, etc.)	0-	 Race - America Black, White, 			
36	or i	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🖾 Divorced	1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🗓 No	Specify:			Specity: Wh	nite		
8	hour Itural	ed k	15. Decedent's Ed		16a. Dece	dent's Usual Occu	pation		16b. K	(ind of Business/In	dustry		
15	in 72 n "na nedic	plet	(Specify only highest gra	de completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retire	e during most of work ed)	ing			,		
212	with giene r thai	Completed	12	College (1-4or 5+)	Admin	strative	Assistan	t	Sa1	Les			
b	othe othe	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle	e, Maider	Surname)			
<u>la</u> r	uld by Aents rked ric ev	To E	Urcle O. Wamsley				Doro	thy F1	etche	er			
ary	sho s ma s ma	•	19a. Informant's Name/Relationship (,	1	-	t and Number or Rui						
Σ	and 2 salth n 27		Linda W. Holloway				nds Drive,	Annapol	lis,	Maryland	21403		
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐	Removal from State	 Place of Dispo cemetery, crer 	sition (Name of matory or other pla	ace) Marc	h 30,	20c. L	ocation - City or To	own, State		
Ē	Pag ment ant: I		4 □ Donation 5 □ Other (Specific	()	Montgomery (Crematoriu	n, Inc. 200)8	Bet	hesda, M	aryland	1	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra		21. Signature of Funeral Service Licer	MO1	305 RO	Name and Addr bert A. Pu	ess of Facility Imphrey Fune:	al Home	/Beth	esda-Chevy	Chase,	Inc.	
	111		23a Part 1 Fyter the disease or com	11.64	17.		in Avenue, I			71and 20814	Approximate		
			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final			or the mode or dy	ing, odon do odraido	or reopiratory	arroot,		Interval Betw Onset and D	veen	
	Physician /Medical	er		disease or condition resulting in death)	. Cardiac								
	Examiner			Due to (or as a c Hyperte									
- 4			Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c									
V	uted ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Cerebro	vascular	Accident	:						
,	be executed ician and burial-transit	Exa	that initiated events resulting in death) Last	C. Due to (or as a c	onsequence of):								
760,	e be ey sician e buria		(Prostat	e Cancer								
687	leath certificate b attending physic I for use as the bi	ledi											
Вох	h cer andin use	N/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf 1 ☐ Live birth 2 [⊒Ectopic pregnan	01/			23d. Date of deliver	*		
		sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at tin		Other (specify)	-			Month	Day Y	'ear	
P.0	The law requires that the do	Physician/Medical	9 ☐ Unknown					T					
	es th gned be de		Part II. Other significant conditions	ontributing to death but r	not resulting in the u	nderlying cause g	iven in Part I.			use contribute to t			
ord	equir en si ould	ted						1 🗓	Yes 2	Proi	oably 4 ∏U	nknown	
Records,	law r as be	Completed by						24a. Wa	s an opsy	24b. Were auto	psy findings a	vailable	
R	The ate h page	Som						per 1□ Yes	formed?	death?	2□ No		
/ita	cian: ertific ctor,	Be (25. Was case referred to medical examiner?			1	26. Place of Deal	h (Check only	one)				
Z	Physician: this certific	၉	1 X Yes 2 No		2 ER/Outpatier	" 3 DOX				6 ☐Other (Special	fy)		
n o	ing P		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	(ear) 28b. Time of Injury	We	1	28d. Describe	how inju	iry occurred			
Sio	Attending r death. sctor: Afte	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be]Yes 2□No						
Division or Vital	lor At after d Direct	Certification:	4 Homicide determined	28e. Place of injury building, etc. (- At nome, farm, str Specify)	eet, ractory, office			(Street a. own, Stat	nd Number or Run e)	ai Houte Numb	ser,	
	pital ours a eral [29a. Certifier 1 X Certifying Ph	ysician: To the best of r	ny knowledgo doot	h occurred at the	time, date and place	and due to th	0.001100/	and manner es	etated		
	the Hospital hin 24 hours the Funeral upletely filled	Medical		niner: On the best of re niner: On the basis of ex and manner state	camination and/or in)	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Med	29b. Signature and title of certifier	A A		29c. Licer	ise number		29d. Da	ate signed (Month,	Day, Year)		
	F > F 0		()	/ 1 / 1 /									

12

31. Date filed (Month, Day, Year) State Registrar

Samuel Semegen, M.D.

32 Registrar's Signature 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D48152

March 28, 2008

08-02361

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Ramon Williams	1- For State Registrar	State of Maryland /	Department of Certificate of	Health and Mental Death		eg. No. 901	io Inno
Physician	1. Decedent's Name (Fire				2. Date of Dear	th Year	3. Time of Death
Medical Examine ম.্		re Williams institution, give street and number)	· · · · · · · · · · · · · · · · · · ·	4b. City, Town, or Location of De	March 25,	2008 4c. County of Deat	1148 hrs
<u></u>	4500 Ritchie Hig	ghway Apt. C		Brooklyn		Anne Arundel	
Funeral Director	5. Social Security Number 215-06-1478	3 1XM 2 F	(In yrs. last birthday) 39 Yrs	Months Days Hours M	8. Date of Bir 08/09/	Co	rthplace (State or Foreign ountry) MD
any	Usual Residence of Dece 10a. State 10b.		10c. City, Town or Locati	on			10d. Inside City Limits
daryland 28a-f show any 1.at once.	MD An	ne Arundel	Bro	oklyn –			1 Yes 2 X No
the Marylanc sa or 28a-f sh	10e. Street and Number 4500 Ritch	nie Highway Apart	ment C	10f. Zip Code 21225		Og. Citizen of What Cou $U_{ullet}S_{ullet}A_{ullet}$	intry?
Baltimore, MD 21215-0036 pemit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	11. Marital Status 1 Never Married 3 Wildowed 4	2 Married Armed Forces? 1 Yes 2 Divorced If Yes, Give Year or Dates:	x No	s Decedent of Hispanic Origin? (es, specify Cuban, Mexican, Pue Yes 2 X No specify:		14. Race - Amer White, etc. Specify:	rican Indian, Black,
hours 'natur	15. Decedent's Educati	ion (Specify only highest grade com	during m	t's Usual Occupation (Give kind ost of working life. DO NOT use		16b. Kind of Business	/Industry
0036 vithin 72 eene. er than '	10		+)	Chef		Food Serv	rice
21215-0036 Juld be filed within 7 Mental Hygiene. Marked other than ic event, the Medica		Middle, Last)			me (First, Middle, I LElizabe	ŕ	
should I had Mer is mar	19a. Informant's Name/R	Relationship (Type, Print)	L .	Address (Street and Number	or Rural Route Nur	mber, City or Town, Stat	
and 2 sho and 2 sho lealth and ten 27 is traumati	20a. Method of Disposition	lliams- Mother		N. Bentalou St. ition (Name of cemetery,	Baltimo	re, MD 21216	
Baltimore, permit. Pages 1 ar Department of He, important: If ite injury or other ir	1 Burial 2 C	remation 3 Removal from State Other Specify:	te crematory or oth Baltimore		3.29.08	Baltimore,	
Balti permit. Departn Importi injury o	21 Signature of Funeral		22. N Joh 11.70	lame and Address of Facility on L.Williams Fi	uneral Di Baltimor	rectors,P.7	Α.
Physician /Medical	23a. Part I. Enter the dise failure. List only on	ease, or complications that caused the cause on each line.	he death. Do not enter the	ne mode of dying, such as cardial Cocaine Intox cation and Cocaine	c or respiratory arr ication	est, shock, or heart	Between Onset and
xaminer	Immediate Cause (Final or condition resulting in	disease death) a. Narcotic (Mo	rphine) intoxi quence of):	eation and Cocaino	-Use		Death
	Sequentially list condition		wen e di				
led nisit	cause. Enter Underlying (Disease or injury that in	g Cause nitiated c					
und transit	events resulting in death	d	quence ory.				
60, tre be executed itysician and burial - transit	X UNPENDED	AMENDED per	fh g877 3-	$-31-08$ vt 23a,27	28a-f per N 28b per m	Œ g878 4/3/08 c. c.870 5-5	amh -N8 vi
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed him 24 hours after death. The this certificate has been signed by the attending physician and upletely filled in by the funeral director, page 2 should be detached for use as the burial - transitical Certification: To Be Completed by Divisional Madical Exiteration:	IF FEMALE: 23b. Was decedent pregn past 12 months?	nant in the 1 Live birth 4 Pregnant at t	2 Fe	tal death 3 Ectopic pre			ry Day Year
the dea	Part II. Other significant	9 Ulkilowii	but not resulting in the u	inderlying cause given in Part I.	23e Did to	obacco use contribute to	the cause of death?
P.O.	3					s 2 No 3 Pro	
Division of Vital Records, Futal or Attending Physician: The law requires to after death. al Director: After this certificate has been sign led in by the funeral director, page 2 should be contification: To Be Completed					24a, Was autor	osy prior to	utopsy findings available completion of cause of
tal Recian: The la	5				1 ✓ Yes	rmed? death? 2 No 1 🗸 Y	′es 2 No
sician: is certification	25. Was case referred to examiner?	Hospital:	nt 2 ER/Outpatient	26.Place of Death (Che		Residence 6 ✔ Othe	er Scene
of Viing Physi		No 28a. Date of Injur (Month, Day,Ye	y 28b. Time of I	njury 28c. Injury at Work?		how injury occurred	ST. SCENE
Sion Vittendi death. ctor: /	1 Natural 5 2 Accident	Pending Found 3/25	/08 Found 1:4	O-pm 1 les 2 IA NO	Unk		
Division of Vital Rec spital or Attending Physician: The tours after death. neral Director: After this certificate filled in by the funeral director, page	3 Suicide 6 XX Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State 4500 Ritch Apt C. Brooklyn, AA						e Highway
Di To the Hospital within 24 hours a To the Funeral I completely filled	Z9a Genitier	ifying Physician: To the best of my ical Examiner:On the basis of exam	knowledge, death occur		and due to the caus	se(s) and manner as sta	ted.
To con	29b. Signature and title o	and manner stated.		29c. License number		29d. Date signed (Me	
	hij	hi, mp		O.C.M.E.		March 26, 2008	
Ø		f person who completed cause of de Assistant Medical Examiner		et, Baltimore, MD 21201			
Stat Registra	191 64 151	y 3ea 2008 32 registrar	s Signature	K)	fa.		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 Month 9:30 a M Armenia Μ. Anderson March 8, 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery

9. Birthplace (State or Foreign Country) Suburban Hospital
5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Dec. 13, 1922 If Under 1 Year I I Under 24 Hrs. 7. Age (In yrs. last birthday) Months Days Hours 1 □ M 2 F 043-12-5131 85 Connecticut Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐ No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 IISA 12633 Georgia Avenue, #101 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 █ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify SpecWhite 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 12 Senior Clerk/Administrator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rocco Abbruzzese Mary Frangione 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6625 Cross Star Court, Sparks, Nevada 89436 Frank Anderson/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition March 13. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 2008 Silver Spring, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. Service Lic 500 University Blvd W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List of ly one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sersis Due to (or as a consequence of): Rectovaginal Fistula Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show at

ms 23a or 7

ı "natural", or item: ledical Examiner n

the

Director

Funeral

þ

Completed

Be

ဂ

Examiner

Physician/Medical

Completed by

Be

မှ

Certification:

Medical

with the Maryland

death v or items 23a

filed within 72 hours after

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int; If item 27 is marked other than '

Department of Health Important; If item 27 any injury or other tr

3altimore, Maryland 21215-0036

certificate be executed physician and s the burial-trans as nse for been signed by the s

Ö

٦

Division of Vital Records,

has page certificate funeral director, this 24 hours after death e Funeral Director:

Sequentially list conditions, if any, leading to immediate cause. Enter U count of Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | Yes 2 | No 3 | Probably 4 Nunknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1∐ Yes 🗶🙀 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 🔼 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 → Natural 2 → Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Rd. Bethesda Mo

2008

To the I within 2 To the I

Hospital or Attending

ò

filled in

completely

Registrar

31. Date filed (Month, Day, Year) MAR

29b. Signature a

Ha 17 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8600 Old Georgetown MD 0 Registrar's Signature

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State amend #5 Per FH G878 4/23/08 eHificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year Matter 9, 2008 7:00 A Apperson Elsie Lorraine 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Prince George's Oxon Hill 7911 Esther Drive If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. April 13, ^{5. 3}579^{5e}38×1141e3 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign 6 Sex 1 □ M 2 F Months Washington, DC 77 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes ŽŽXIo Prince George's Oxon Hill Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 7911 Esther Drive 20745 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 🛣 No Yes, Give White 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker In Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anderson Virginia Schuard William Albert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Donald D Apperson / Husband 7911 Esther Drive Oxon Hill, Maryland 20745 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐ Removal from State 03/14/2008 Clinton, Maryland Resurrection Cemetery 4 Donation uneral Service License 22. Name and Address of Facility George P. Kalas Funeral Home PA 21. Signature 6160 Oxon Hill Road Oxon Hill, Maryland alsa Approximate Interval Between Onset and Death 23a. Part I Enter the diseast, or complications of at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one of unle on each line. Immediate Cause (Final disease or condition resulting in death) LOU GEHRIG DISEASE Due to (or as a consequence of): SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery pregnant 3 Ectopic pregnancy Month Day nonths? 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. XX No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

Physician /Medical Examiner Examine the death certificate be executed

Physician

/Medical

Examiner

10a. State

Funeral

Director

ral", or items 23a or 28a-f show Exa⊓iner must be notified at

'natural", or items 23a

or other traumatic event, the Medical

permit. Pages 1 and 2 should be filled will Department of Health and Mental Hygien. Important: If Item 27 is marked other thrown injury or other traumarin

Director

Funeral

þ

Be

၉

death with the Maryland

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-tran Physician/Medical detached for use be Completed director. Be Certification: To λq

ģ

Medical

Division or Vital Records, P.O. Box 68760.

of or Attending Physician: after death. Director: After this certification

IF FEMALE:	
23b. Was dece	dent
in the pas	t 12 n
in the pas 1 ☐ Yes	2 🔼

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only

		24a. Was an autopsy performed 1 Yes 2 △
25. Was case referred to medical	26. Place of Death (C	heck only one)

۵٠.	examiner?		
27.	Manner of Death	-=	
	1ÆNatural	5 Pending investigation	n

Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Ye 6 ☐ Could not be

2	ER/Outpatient	3∟
ar)	28b. Time of Injury	М

Other: 4 Nursing Home 5 A Residence 6 Other (Specify) DOA 29c Injury at

(Month, Day Year)	Injury	М	Work? 1 ☐ Yes	2 🗆 No
28e. Place of injury - At he building, etc. (Special	ome, farm, stree fy)	t, facto	ory, office	

**Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an

	_
d due to the cause(s) and manner as stated.	
at the time, date and place, and due to the cause(s)	

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

37347

29b. Signature and title of certifier

2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.

29c. License number MD0000040564 29d. Date signed (Month, Day, Year) March 12, 2008

1 Yes

2□No

30. Name and address of person who completed cause of death (Item 23a) Type, Print)

MDEdward L. Mosley

980 Highway 28 Suite #203 Jasper Tennessee

31. Date filed (Month, Day, Year)
MAR 1 8 2008 State Registrar

			1 - For State Registrar	State of Mary		artment <i>rtificate</i>			and Me		jiene eg. No.	008	1023	5
	Physici	an	Decedent's Name (First, Middle, Last)	2. Date of Deal Month	th Day	Year	3. Time of Death							
1	/Medi	cal	Emory Russe		Sr.	# 65 T		March			14.		22:41 P	4
	Examir	ner	4a. Facility Name (If not institution, give s			Location of	f Death		4c. Co	ounty of Death				
	Funeral		9 Shaggy Oak Drive 5. Social Security Number 6. Sex		yrs. last birthday)	If Under 1		If Under 2		8. Date of Birth		Cecil 9. Birth	place (State or Foreig	an a
в	Director		231-56-5242	M 2□F 64	Yrs.	Months	Days	Hours	Min.	(Month, Day) March 1	Year)	Cou	_{ntry)} ginia	
	and w		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	cation							10d. Inside City Limits	_
	Maryli f sho	ō	Maryland Cecil		E1kton	odion							1 ☐ Yes 27 N	
	28a	rect	10e. Street and Number			10f. Zip C	Code			1	0a. Citize	n of What Cou		
	d within 72 hours after death with the Maryland Jene. Ir than "natural", or Items 23a or 28a-1 show I're Medical Evanting trung the Loutified at	Funeral Director	9 Shaggy Oak Drive					901				d Stat	•	
	ms (ner	11. Marital Status	2. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decede	nt of His	spanic Orig	gin? (Spec	cify Yes or No-	14.	Race - Ameri Black, White,		
36	or It	by Fu	1 Never Married 2 Married	1 ☐ Yes 2000No If Yes, Give		1 ☐ Yes 2		Specify:	, 1 00110 11	110411, 610.7	Sı		ite	
Maryland 21215-0036	hour tural	ed b	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educ	Year or Dates:				tion				***************************************		
15	n'na n'na	Completed	(Specify only highest grade	completed)	(Give	dent's Usual kind of work DO NOT use	done de	uring most	of working	g		of Business/In	•	
212	d within giene. or than "	E	Elementary (Secondary (0-12)	College (1-4or 5+)	P	aint D	enai	rtmen	t			nufact tomoti	0	
P	be filed ital Hygi of other	Be	17. Father's Name (First, Middle, Last)							(First, Middle, I			V C	
yla	2 should be and Mental is marked is marked is marked is an an arked is a arked is a arked i	To E	Albert Asbury					Vi	rgie	Hamilt	on			
Zar	is 1 and 2 should be filed of Health and Mental Hyg Item 27 is marked othe other traumatic event,		19a. Informant's Name/Relationship (Typ							Route Number	_			
e,	is 1 and 2 of Health a Item 27 is other train		Shirley A. Asbury 20a. Method of Disposition						, Ell	kton, M		tion - City or To	921	_
altimore,			1 Burial 2 □ Cremation 3 □ Re	moval iloili otate	Ob. Place of Dispo cemetery, crer			1 -	March	n				
I	E 6 3	. 19	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Pupers Service Licens >	/ N	orth Eas				17, 2	2008 I	North	East,	Mary1and	_
Ba	permit. Depart import any inj once.	1	Med to	and the									yland 2190	ን 1
E	Physician and whisician and hysician and prize bright tunner transit.	Icai Examiner	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	MONIC		in a	bin.	nage	2				Interval Between	5
	The law requires that the death certificate be executed tie has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic preg				w= ==	230	I. Date of delive Month	ery Day Year	
Division of Vital Records, P	quires thai in signed t uld be det	ρ	Part II Other significant conditions control	ibuting to death but no	t resulting in the u	nderlying cau	ise giver	n in Part I.			oacco use	_	he cause of death? Dably 4 □Unknown	n
900	aw re	Completed	Idenal Sail	inc						24a. Was a		24b. Were auto	ppsy findings available	е
Œ	The lav ate has page 2	E O	N SAPATONS	CICOLI						autops perform	ned?	death?	mpletion of cause of	
/ita	striffic ector,	Bec	25. Was case eferred to medical examiner?					26. Place	of Death	Check only on	-			
<u></u>	hysia this o	P.	1 ☐ Yes 2 ZiNo		2 ER/Outpatien			4 🗀 Nur:	sing Hom	e 547 Reside	nce 6	Other (Specif	(y)	
ב	ding F	lon	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Yea	ar) 28b. Time of Injury		Work?			Bd. Describe ho	w injury o	ccurred		
<u>s</u>	I or Attending Physician: after death. Director: After this certifice in by the funeral director, p	lcat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury -	At home farm, etc.	M factory		es 2□N		Bf Location (St	root and A	lumbos os Rum	al Route Number.	_
<u>≥</u>	after Dire	Certification:	4 Homicide determined	building, etc. (S)	pecify)	eet, ractory, t	SHICE		20	City or Town		iumber or Hure	ar nodie Namber,	
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edicai C	29a. Certifier Certifying Physic (Check onto one)	cian: To the best of my or: On the basis of exa and manner stated.	knowledge, death mination and/or inv	occurred at restigation, in	the time	e, date and inion, death	place, an	nd due to the ca	ause(s) an ate and pla	d manner as s ace, and due to	tated. the cause(s)	
	To the Ho within 24 I To the Fu completely	Me	29b. Signature and title of certifier	1.0.				number	_	29	9d. Date s	igned (Month,	Day, Year)	
)			////////	11 N M	7	1	14:	5/5	5	C	03/	18/2	2008	
	8		Druxin M	ple ed cause o dea	(Item 23a) (Type,	Print)	15	1.5	irte	309	6	KRK	2008 ND 3 (9)	2/
	Sta Registr	te ar	31. Date filed (Month, Day, Year) MAR 1 8 2008	32. Registrar's S	Signature	1								

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

RAYINDER SINDAWANI. MD

MAR 3 1

R. Sindlun

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

SARBARA

Registrar DHMH 17 Rev 1/2001 29c. License number

D61614

4 POST OFFICE ROAD SUITE IOL WALDORF, MD. 20602

29d. Date signed (Month, Day, Year)

march 25th, 2008.

State of Maryland / Department of Health and Mental Hygiene Per FH G879 5/02 Certificate of Death

State of Maryland / Department of Health and Mental Hygiene Per FH G879 5/02 Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician Peter B. BERMAN 1:00 A M March 16, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 1801 E. Jefferson St. #G-2 Montgomery Rockville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Days Months 1 XM 2 ☐ F Yrs. Director 93 March 1, 1915 Massachusetts 033-05-6634 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10b. County 1 X Yes 2 □ No Maryland Montgomery Rockville Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or be r r Items 23a c liner must be 1801 E. Jefferson St. 20852 United States death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? ural", or Item I Examiner n Black, White, etc. and 2 should be filed within 72 hours after ealth and Mental Hygiene. 2□N1942-1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No 1945 Specify: white ģ 3 Widowed 4 Divorced Year or Dates: "natural" Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Container Business 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked Minnie Kaufman Edward Berman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: If item 27 is ury or other tra 1801 E. Jefferson St., #G-2, Rockville, MD Anne Berman, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ott 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State Lindwood Memorial Park 03/19/08 4 Donation 5 Other (Specify) Randolph, MA 22. Name and Address of Facility
Torchinsky Hebrew Funeral Home 21. Signature of Fyrman Service Licens 254 Carroll St., NW, Washington, DC
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20012 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) Aortic Stenosis
Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate class (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine executed burial-trai Due to (or as a consequence of) Box 68760. nding physician pe Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter in the past 12 months? 1 ☐ Yes 2 ☐ No ρ Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. the 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ð 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 XNo page (certificate 1□ Yes Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🕅 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 TVNo this After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident To the Hospital or Atternwithin 24 hours after dead To the Funeral Director in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide 29a. Certifier 1 ី Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D40203 08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20815 William E. Battle, MD, 5530 Wisconsin Ave., #750, Chevy Chase, MD 31. Date filed (Month, Day, Year) 32. Paristrar's Signature State 2008 MAR 17 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month BERG. PHYLLIS 12:28 P^M 2008 March 15 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b, City, Town, or Location of Death Holy Cross Hospital Montgomery Silver Spring 7. Age (In yrs. last birthday If Under 1 Year If Under 2 Months Days Hours 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 1 □ M 2 🕽 F April 14, 579-50-3727 69 1938 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Montgomery Silver Spring 10g, Citizen of What Country? 10e. Street and Number 20902 United States 1131 University Blvd., W. #419 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🏋 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pan American Health Elementary/Secondary (0-12) College (1-4or 5+) 4 <u>Administrative Assistant</u> <u>Organization</u> 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Anne Tomares Nathan Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod 20902 19a. Informant's Name/Relationship (Type. Print) 1131 University Blvd., W. #419, Silver Spring, MD Morton Berg, Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 03/18708 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garden of Remembrance Memorial Park Clarksburg, MD 21. Signature of Funeral Service 22. Name and Address of Facility
Torchinsky Hebrew Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20012 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiopulmonary Arrest Due to (or as a consequence of): Septic Shock Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Pneumonia Due to (or as a consequence of): Radiation Pneumonitis IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Hypercapnea 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an Renal Failure autopsy 2 X No 1□ Yes Metabolic Acidosis 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital:

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

Funeral

Director

show aţ

28a-f

ò

23a

items

o.

'natural",

than

marked other

permit. Pages 1 and 2 s
Department of Health ar
Important; If Item 27 is
any injury or other trau

n and Mental F

death v

72 hours after

filed within Hygiene.

pe

Maryland 21215-0036

Baltimore,

Box 68760.

O

م

Records,

or Vital

Division Hospital or Attending notified

the Medical Examiner must be

Director

Funeral

þ

Completed

Be

certificate be executed and burial-trar the as attending properties for use as the à signed to

page 2 certificate this After

Physician/Medical

þ

Completed

ဥ

Certification:

Medical

27. Manner of Death

1 X Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

To the Hospiu...
within 24 hours after
To the Funeral Dir

after

Director:

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAR

17

5 Pending investigation

6 Could not be

29c. License number D 0064100 29d. Date signed (Month, Day, Year) March 15, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Smitha Bhikkaji, M.D., 1500 Forest Glen Road, Silver Spring, MD

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

1X Inpatient

28a. Date of Injury (Month, Day Year)

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** :55 am M 2008 MARY LONIE BUTLER Trurch /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Plata If Under 1 Year I If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 ☐ M 2 🛛 F 96 Director 215-88-3801 09-07-1911 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Charles Newburg MD 10f. Zip Code 10g, Citizen of What Country? 10e Street and Number 20664 USA 9640 Crain Hwy Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: Be Completed by 3 Widowed 4 Divorced **Black** 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Naval Research Lab Maintenance Worker 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John I. Proctor Mary Harley ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanette Butler / Granddaughter 4705 4th Street, NW Washington, DC 20011 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Ignatius Cemetery 03-18-2008 Port Tobacco, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Marshall's Funeral Home of MD 21. Signature of Funeral Service Licensee D. GRAY (7) 4308 Suitland Road Suitland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MARNOSCLEMOSIT DVANCER **Physician** /Medical Due to (or as a consequence of): Examiner IDBUTY. VI GA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>}</u> 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 2 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Physician:

for ed by the a signed by the sign of the sign certificate has page funeral director, this After Hospital or Attending 24 hours after death. filled in by completely within 2

items 23a or 28a-f shov ner must be notified at

"natural", or

other traumatic event, the Medical Examiner

marked other

Is marked of

t of Health a

permit. Pages Department of Important: If it any Injury or o

and burial-trar

physician

the as

Pages 1 and 2 should be

State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

address VEORG

person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

31. Date filed (Month, Day, Year) MAR 1 8 2008

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Pay, Year)

State Registrar

Registrar MAR 1 8 2008

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ws To

3001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 10241 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month 3130 P M 80 6 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Berliv
If Under 1 Year | If Under 24 Hrs. | Hours | Min. (reveral Hospita lantic vorcester 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Yea May 26, 1 Birthplace (State or Foreign
Country) 1₩ 2□F Days Hours 200-24-3836 76 Yrs. Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1√2 Yes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2250 Bear Den Road #206 21701 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Minister Ministry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Franklin A. Bracken Emily Griffith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggie J. Bracken / Wife 2250 Bear Den Road #206, Frederick, MD 21701 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Grandview Cemetery 3/20/08 Johnstown, Pennsylvania 4 ☐ Donation _ 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses ROBERTINE DATEEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 23a. Part1. Enter the disease or complication shock, or beart failure. List only one cau Approximate Interval Between Onset and Death e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying

Examiner or Attending Physician: The law requires that the death certificate be executed iis certificate has been signed by the ettending physician and director, page 2 should be detached for use as the burial-trar 000 Ö م Records, DiB 3836 To the Hospital or Attending Physician: The within 24 hours elied death.
To the Funeral Director: Alier this certificate i completely filled in by the funeral director, pag Division of Vital 46-34

Medical Certification; To Be Completed by Physician/Medical Examiner

Physician

Examiner

Funeral

Director

permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If I tem 27 is marked other than "natural" ~-! any injury or other traumatic even.

Physician /Medical

/Medical

Be Completed by Funeral Director

2

Cause (Disease or injury that infitated events resulting in death) Last	c. Due to or a a consei		isease	ure						
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 6 9 □ Unknown	al death 3 □Ectopic	pregnancy (specify)		23d. Date of delivery Month Day Year					
Part II. Other significant conditions co	ntributing to death but not res		g cause given in Part I.	23e. Did tobacc	eo use contribute to the cause of death? 2 No 3 Probably 4 Unknown					
Athal Hip	rillation			24a. Was an autopsy performed						
25. Was case referred to medical examiner?	26. Place of Death (Check only one)									
1 ☐ Yes ② No	Hospital: npatient 2	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 ☐ Residence	6 ☐Other (Specify)					
27. Manner of Death 1 Artatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28d. Describe how injury occurred							
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, factify)	ory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)					
29a. Certifier (Check only one) 2 Medical Example	sician: To the best of my known of the common stated.	owledge, death occurr ation and/or investigat	ed at the time, date and place on, in my opinion, death occ	e, and due to the cause curred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)					
29b. Signature and title of certifier			29c. License number	294	Date signed (Month Day Year)					

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

ompleted cause of death (Item 23a) (Type, Print)

32. Regist

MAR 1 8 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ${\tt A}^{\,{\sf M}}$ 15, 2008 2:15 March BRAULT MARGARET ELIZABETH /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Frederick Memorial Hospital Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 ☐ M 2 🖾 F Yrs. Director 88 April 11, 1919 Washington, DC 577-22-8980 Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits show 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2 ☑ No Director Thurmont Maryland Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō be 13631 Graceham Road 21788 United States items 23a "natural", or items 23a Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 72 hours after 1 ☐ Yes 2 🖾 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: þ 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d be filed within 7 antal Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 5+ Physician Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Pris is marked of Charles Cyprian Callan Aurelia Magdalene Luskey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) if Health 13631 Graceham Road Thurmont, Maryland 21788 Charles E. Brault / son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o March 19, 1 ™ Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Blue Ridge Cemetery 2008 Thurmont, Maryland 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Sign aure of Funeral Service Licensee 104 E. Main Street Thurmont, Maryland 21788 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CARBIOVASCULAR disease or condition resulting in death) ATHERO SCLEROTIC 10 YRS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner certificate be executed burial-trar Due to (or as a consequence of): Box 68760, physician Physician/Medical the IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, by HYPERTEN SION DIABETES MELLITUS, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No DEMENTIA certificate 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No မ 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After t completely filled in by the funers 27. Manner of Death 28d. Describe how injury occurred Certification: 5 ☐Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier MD D21936 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 650 THOMAS JOHASON DR FREDERICK 21702 A. DONELSON MD 31. Date filed (Month, Day, Year) 32. Registrans Signature State MAR 1 8 2008 b Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death **Physician** $\underline{\underline{A}}^{\mathsf{M}}$ 13, Eloise W. March 2008 2:30 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6448 Sunset Drive Frederick Frederick
If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2 🛛 F Director Jan. 23, 022-28-8101 71 Massachusetts Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Frederick Frederick 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 6448 Sunset Drive 21702 filed within 72 hours after death Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No ģ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry runt. Pages 1 and 2 should be filed withir partment of Health and Mental Hygiene outant: If item 27 is marked other than 'Injury or other traumatic months. Elementary/Secondary (0-12) College (1-4or 5+) Medical Transcriptionist Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Guy Edward Jewers Eloise Logan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peter P. Brandt/ Husband 6448 Sunset Drive, Frederick, Maryland 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or 4 Donation 5 Dother (Specify) Stauffer Crematory Inc 3/17/2008 Frederick, Maryland 21. Signatur Juneral Service 22. Name and Address of Facility Stauffer Funeral 1621 Opossumtown Homes Pike, P. A. Frederick, Maryland21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final (ance Physician disease or condition resulting in death) /Medical Due to (or as a contequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed burial-transi and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician I for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 1 Yes 2 No 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the s should be detached 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? Be (26. Place of Death (Check only one, Hospital: 1 | Inpatient Other: 4 Nursing Home 5 KResidence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No ie Hospital or Attendi 24 hours after death. ie Funeral Director: A death. 2 Accident completely filled in by the 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D43091 March 13, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VΟ

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR

Saeed Zaidi MD 801 Toll House Avenue E-1, Frederick, Maryland 21701

32. Registras Signature

8 2008

			For State Registrar		5							
			1. Decedent's Nam	e (First, Midd	le, Last)							
	Physici /Medi		JERRARD EVANS									
100	Examir		4a. Facility Name (/	f not institutio	n, give stre							
	Examin		FREDERICK MEMORIA									
-			5. Social Security N		6. Sex							
н	Funeral Director		none		1 X M							
	radi 16. Njihighi a		Usual Residence of	Decedent								
	and and		10a. State	10b. County	,							
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. mportant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ctor	Maryland	Fre	ederi							
	± 8 5	ě	10e. Street and Nu	mber								
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f st any Injury or other traumatic event, the Medical Examiner must be notified once.	Be Completed by Funeral Director	1129 1	Provid	ence							
	dea Lining	nei	11. Marital Status		12.							
10	r ite	E	1 XNever Married 2 Married									
036	ours a ral", o Exam	d by	3 ☐ Widowed	4 Divorce	t							
15-0	n 72 h "natu edical	letec	15. Decedent's Educat (Specify only highest grade of									
212	l withir jiene. r than the M	ошо	Elementary/Seco	ndary (0-12)								
D	filed Hyg the	O	17. Father's Name (First, Middle, Last)									
Baltimore, Maryland 21215-0036	ermit. Pages 1 and 2 should be filed with lepartment of Health and Mental Hyglene nportant. If Item 27 is marked other than ny Injury or other traumatic event, the Noce.	To Be	Jerra	ard	Bro							
<u> </u>	shou ma	ļ~	19a. Informant's N	ame/Relation	ship (Type.							
N.	and 2: alth a 27 is er trau		Jerrard	Brow	_							
ore	es 1 a of He filter		20a. Method of Disp 1 XBurial 2	oosition Cremation	3 □Rem							
ij	Pag ment tant: I		4 □ Donation	5 Other (Specify)							
Ball	Departi Departi Importa any Inji		21. Signature of Fu	ineral Service	Licensee							
	20-00	_	ISOU!	mons	10							
				he disease, c art failure. Lis	r complicat t only one							
	Physician		Immediat Cause disease or condition resulting in death)	(Final n	a							
	/Medical		resulting in death)									
	Examiner											
	24.7/2	Je.	Sequentially list co if any, leading to in	nditions, nmediate	D D							
	cuted d ansit	Ē	Cause (Disease or that initiated events	Iniurv								
0,	e exe(an an rial-tr	Exa	resulting in death) I	_ast	Ŭ							
Box 68760	death certificate be executed e attending physician and d for use as the burial-transit	ician/Medical Examine			d							
39	ertifica ing ph	Med	IF FEMALE:									
30	ath ce tend	an/	23b. Was deceden in the past 12		23c.							
-	des e at ed fo	S		nontns / ⊒ No								

BROWN III March 10, 2008 10:00 PM et and number 4c. County of Death 4b. City, Town, or Location of Death AL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) Days (Month, Day, Year) March 10,2008 2∏ F 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No ck Frederick 10g. Citizen of What Country? 10f. Zip Code Ct. 21703 United States Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. If Yes, Give Year or Dates: 1 ☐ Yes 2 🗓 No Black Specify. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry ompleted) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) none 18. Mother's Name (First, Middle, Maiden Surname) own. Sr. Keonna Hyater Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1129 Providence Ct./ Frederick, Maryland 21703 Father 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State oval from State Mount Olivet Cem. 03/15/2008 Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike/ Frederick, MD 21702 tions that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, cause on each line. 1 hr,54 min. Severe prematurity Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of) If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 💢 Inpatient 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation (Month, Day Year) Injury 1 □ Yes 2 □ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🔀 Çertifylng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3/10/08 m 0059166

Division or Vital Records, P.O has been signed by the page 2 certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

> State Registrar

32. Registrar's Signature MAR 1 8 2008

Kalpana Helmbrecht, MD / 400 West 7th St./ Frederick, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 10215

Austin Demetrius		wn · For State	Sta	te of Ma	ıryland	/ Depar	rtment of <i>ificate of</i>	Health	and	Menta	я нуд		- N-	21) [[3 1024
	R	egistrar . Decedent's Name (First Middle	Last)		Cert	IIICale OI	Dealii			2.	Date of Dear	eg. No		3.	Time of Death
Physicia Medical Examin	1.4	AUSTIN 1	DEMETR	IUS BR	OWN							Month March 11,	2008	Year		0603 hrs
5,0		la. Facility Name (if n		, give street a	ind number)		4	b. City, To		ocation of	Death	h 4c. County of Death Charles				
;		4450 Livingst			17.	- // /-	at histheau)	Indian If Under		If Under	24Hrs 18	8. Date of Bir			. Birthpl	ace (State or Foreign
Funeral Director		5. Social Security Nur		S. Sex		je (In yrs. la		Months		Hours	Min.			- 1	Countr	y) INGTON, DC
Director		218-04-683		1 X M 2	F	39	Yrs.			l		12/19	1900	<u> </u>	MASII	INGTON, DC
áu h	-	Usual Residence of D 10a. State	Ob. County			10c. City,	Town or Locati	on								od. Inside City Limits
nd show :	_	MD	CHARL	ES		IN	DIAN HE	LAD							i_	Yes 2 X No
faryla	Director	10e. Street and Numb	per					10f. Zip (en of What		
3a or		4450 LIV	VINGST				- Lie w	206		amia Osiair	2/500	cify Yes or No		A Race - A		n Indian, Black,
th with		 Marital Status Mever Married 	2 Ma		med Forces		S. 13. Wa	es, specify	Cuban,	Mexican, I	Puerto Ri	ican, etc.)	, I.	White, e	tc.	
er dea		3 Widowed		orced If Yes, G	live Year	No No	1_	Yes 2	No	specify:			s	Specify: I	BLAC	K
vurs aff	함	15. Decedent's Edu		or Dates	S:	mpleted)	16a. Deceden	t's Usual C	ocupatio	on (Give ki	ind of wo	rk done d)	16b. Kii	nd of Busin	ess/Ind	ustry
6 72 hc	efe	Elementary/Secon	dary (0-12)	Col	liege (1-4 or 2	5+)	CUSTO						PHC	TOGR/	АРНҮ	
003 within yiene.	Completed	17. Father's Name (F	imt Middle	Last)			COSTC	WILL I				First, Middle,				
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	a)	AUSTIN]			BROWN							LDA B				
212 ould by I Ment S mark	P P	19a. Informant's Nam					19b. Mailin	g Address	(Street	and Num	ber or Ru	ral Route Nu	imber, Cit	y or Town,	State, Z	Cip Code)
MD d 2 sho d 2 sho lith and n 27 is aumati		TONYA P			ID	120b I	Place of Dispos					OURT,		ocation - C		
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Dispo	_	3 Rem	noval from S	atets (crematory or ot	her place)			2/2	0/2008	DO	мгргт	· м	ARYLAND
Baltimore, bermit. Pages I ar Department of He Important: If ite	ļ	4 Donation 5	Other S	ecify:		SI.	JOSEPH'S							ппкы	, 11	HKT LIAND
Baltimo permit. Page Department of Important: injury or ott		21 Squature of Fun LYDIA C	. THOR	NTON J	IOHNSC	N	1 34	.39 L	I V I N	GSTON	N KOA	OME, P	DTAN	HEAD	, MD	20640
Physician		23a. Part I. Enter the failure. List only	disease, or	complications	s that cause	d the death	. Do not enter	the mode o	f dying,	such as ca	ardiac or	respiratory a	rrest, sho	ck, or hear	1	Approximate Interval Between Onset and
/Medical taminer		Immediate Cause (F	inal disease	a. Guns	hot Wou	nds (2) o										Death
iammer		or condition resulting	g in death)	Due to	(or as a cor	sequence o	of):									
	ē	Sequentially list con if any, leading to im-	mediate	Due to	(or as a cor	sequence o	of):									_
	aminer	(Disease or injury th	at initiated	c. Due to	(or as a cor	sequence o	of):									
uted nd ransit	Exa	events resulting in d	ieath) Last	d		<u> </u>										
(0, e be executed ysician and burial - transit	edical	UNPENDED		AME	NDED		_									
Box 68760, e death certificate be the attending physic of for use as the burned for use	/Me	IF FEMALE: 23b. Was decedent p	pregnant in t	23c.	. If yes, outo	come of preg		etal death	3	Ectopic	c pregnar	ncy	230	d. Date of d Month	ielivery Da	ay Year
K 68	sician/M	past 12 months	?	4	ruped.	at time of d		other (Spe	cify)				1			
BO) e death the att	Physi	1 Yes 2 N		known g	Unknown		resulting in the	undorlying	. cause (niven in Pr	art I	23e. Dio	tobacco	use contrib	oute to t	he cause of death?
Records, P.O. Box 68766 The law requires that the death certificate cate has been signed by the attending phy page 2 should be detached for use as the b	by P	Part II. Other signif	ficant condi	tions contri	buting to de	ath but not	resulting in the	underlying	, cause (given in ra	DI (1.			/ No 3		
Division of Vital Records, P.O. tad or Attending Physician: The law requires that the rs after death. "In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach												24a. W		24b. W	ere aut	opsy findings available ompletion of cause of
COFC law re has be	Completed										_	pe	topsy rformed? s 2 N	de	eath?	
Re(: The iffcate		25. Was case refer	red to medic	al					26.Place	e of Ceath	(Check	لنفا		<u> </u>		
/ital sician sis cert lirecto	o Be	examiner?	2 No	Hospita	il: 1 Inpa	atient 2	ER/Outpatie	nt 3 🔲 [OOA	Other ₄	Nursin	g Home 5		ence 6 🗸		Scene
of \ng Phy	-	27. Manner of Deat		28	Ba. Date of (Month, Da	Injury ny,Year)	28b. Time o	f Injury		iry at Wor		28d. Descri		jury occurre	ed	
ion tendir leath. tor: A	atio	1 Natural 2 Accident		idirig	Mar 11, 20	80	FOUND: 0600 hrs			Yes 2 ✓		206 Locatio	n (Street	and Numbe	er or Rui	ral Route Number, City
ivis I or At after d Direc	Certification:	3 Suicide	6 Co	ıld not be			home, farm, str	eet, factor	y, office t	building, e		or Tow 4450 Living	n State)			
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate I completely filled in by the funeral director, page		4 V Homicide 29a. Certifier				Multi-Fam	dae dooth oo	urred at th	e time. d	ate and p	lace, and	due to the c	ause(s) a	nd manner	as state	ed.
To the H within 24 To the Fi	Medical	(Check only 1 one) 2	Medical Ex	aminer: On th	ne basis of e	examination	and/or investig	gation, in m	y opinio	n, death o	ccurred a	at the time, d	ate and pi	ace, and d	ue to tin	
To To cor	Ě	29b. Signature and	title of certif			· · · · · · · · · · · · · · · · · · ·	-	29		se numbe	r					nth, Day,Year)
		Mline	/		M)	-			0.C	.M.E.			Ivia	arch 12, 2		
		30. Name and addr			eted cause	of death (Ite	em 23a) niner 111	Penn S	treet. I	Baltimo	re, MD	21201				
106		Melissa Bra		-}	di di	a		-						-20-		
S	tate	31. Date filed (Mon	MAR	8 200	8 /4	strar's Signa	15 6	poete	1							

			1 - State of Mary		artment of rtificate of			giene Reg. No. 2		0246		
無	Physici		Henry William Reronola Ir									
	/Medio Examin		4a. Facility Name (If not institution, give street and number) Union Hospital	h	4c. County Cec	il	n					
	Funeral Director		5. Social Security Number 146-60-9808 Usual Residence of Decedent 6. Sex 1 1 1 1 M № 2 □ F 45	n yrs. last birthday) Yrs.	If Under 1 Year Months Days			v. Year)	9. Birthplace (S Country) New Jer			
	the Maryland 28a-f show notified at	rector		Elkton	10f. Zip Code			10g. Citizen of	1 🗆	ide City Limits		
-0036/	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ted by Funeral Director	10 Conley Court 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedents Education (Specific party beginning for the properties)	16a. Dece	2192. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 🗓 No	Hispanic Origin? (ban, Mexican, Puel Specify:		Specifi	ed State e- American India ck, White, etc. White usiness/Industry	American Indian, White, etc. White		
21215	ed within 7 /giene. er than "n t, the Medi	To Be Completed by	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10	`life.	ruck Dri	ver		Truc				
yland	ould be file I Mental Hy Iarked oth		17. Father's Name (First, Middle, Last) Henry William Bergholz, Sr.			Doris	me (First, Middle	3				
Baltimore, Maryland 21215-0036	ages 1 and 2 sh int of Health and t; If Item 27 Is in or other traum		TELEBURAL 2 LIGHT STATE TO STATE	10 Co 20b. Place of Dispo cemetery, cre-	onley Consistion (Name of matory or other pl	ع عمام	on, MD 2 h 21,	21921 20c. Location	- City or Town, Sta	ate		
Baltin	permit. Po Departme Important any injury once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Eglington H		ry 2008 ress of Facility e for Fun ockton St			boro, NJ D 21921			
1	by Medical Examiner and for use as the burnel-transit of for use as the burnel-transit	lical Examiner	23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a condition of the con	ocarclia onsequence of):		erction	ic or respiratory a	mest,	Interv	oximate all Between t and Death		
.O. Box 6	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome pf 1 Live birth 2 in the pregnant at time pregnant at time place.	Fetal death 3	⊒Ectopic pregnan ⊒ Other <i>(specify)</i>	icy		1	ate of delivery onth Day	Year		
Δ.	law requires that the de as been signed by the a 2 should be detached f	þ	Part II. Other significant conditions contributing to death but r	23e. Did 1 □	tribute to the caus							
I Records,	The ate has page	Completed					24a. Was auto perf 1 Yes		Were autopsy fine prior to completio death?	n of cause of		
Division or Vital	Attending Physiclan: r death. ector: After this certific by the funeral director,	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 New Natural 5 Pending investigation 3 Suicide 6 Could not be determined 4 Homicide 4 Hospital: 1 Hospital: 28a. Date of Injury (Month, Day Y) 28b. Place of Injury building, etc. (10 Homicide)	- At home, farm, st	of 28c. In W	ther: 4 Nursing	Home 5 ☐ Res 28d. Describe	h (Check only one) me 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	the Hospital or hin 24 hours afte the Funeral Din npletely filled in I	Medical C	29a. Certifier (Check only one) 1	camination and/or Ir						ause(s)		
	To the within To the comple	Me	29b. Signature and title of certifier M. Smb			nse number		29d. Date signed March	sth, 200			
	/ Sta	ate	30. Name and address of person who completed cause of death of the street with	Inion Ho	Print)	Ellito	n, Mi	0 210	009			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Leroy Blake, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 8. Date of Birth
(Month, Day, Year)
Sept. 25,1926 If Under 24 Hrs. 5. Social Security Number Sex XOXM 2□F Age (In yrs. last birthday) if Under 1 Year Birthplace (State or Foreign Country) **Funeral** 81 Yrs. Maryland 218-20-5821 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 1 ☐ Yes 2 No Director MDPreston Caroline 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3910 Frazier Neck Road 21655 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Black Specify: ρ 3 ☐ Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Agriculture traumatic event, the Crop Farmer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Albert Blake Lydia Moaney 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marjorie S. Blake/Spouse 3910 Frazier Neck Rd., Preston, MD 21655 injury or other permit. Pages 1 an Department of Heal Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State Mt. Pleasant Cemetery 03/22/08 Preston, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom, Funeral Home, 21. Signature of Funeral Service Licensee Wristex 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dving, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) www **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 9 I Inknown 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 2 No 3 Probably 4 Unknown 1 Tyes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 □ No 1 ☐ Yes 2 ☐ No 1∐ Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely and manner stated. To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8221 Teal DR. Saite 302 Easton. MD MD David H. Smith, 31. Date filed (Month, Day, Year) **MAR 1 9 2008** 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

AS 5

ORIGINAL

20

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** George P. Blundell 18, 2008 12:15 A^M March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 3620 Littledale Rd, Apt. T - 104Kensington Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number 6 Sex Birthplace (State or Foreign Country) **Funeral** Days 1 → M 2 □ F 93 July 29 1914 Mississippi Director 408-56-7657 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
nt: If item 27 is marked other than "naturai", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 ☑ No Director Marvland | Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 7 3620 Littledale Rd, Apt. T-104 20895 United States Funeral 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status "natural", or iten edical Examiner Black, White, etc. 1 Tyes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Specify: à 3 Widowed 4 Divorced Completed er than "natur the Medical E 16a Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 7.27 is marked other than "... r traumatic event College (1-4or 5+) Elementary/Secondary (0-12) Pathologist Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank H. Blundell ည Adeline Schafer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: if item 27 any injury or other tr. once. Brian Blundell/Son P.O. Box 1768, Rockville, Maryland 20849 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Removal from State Omps Crematory 3/21/2008 4 □ Donation 5 □ Other (Specify) Winchester, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rosedale Funeral Home 917 Cemetery Rd. Martinsburg. WV 25404 Approximate Interval Between Onset and Death 23a. Par 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, so M, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Parkinson's Disease Physician Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl for use as t IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 ☐ Yes 2 ▼ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has b irector, page 2 sl autopsy 1∐ Yes 2√∑ No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 1 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 🔀 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA P this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 💆 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number March 19, 2008 D40216

12

State 31. Date filed (Month, Day, Year)
Registrar MAR 3 1

MAR 3 1 2008

Dennis Cullen, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



#101 Bethesda, Maryland 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month March 21, 2008 8:30 P. M Wilda Mae Biser 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Washington 10623 Crystal Falls Dr. Hagerstown If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 1 M 2 XF 76 Yrs. 217-28-5629 Sept. 28, 1931 Maryland Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Md. Washington Hagerstown 10g. Citizen of What Country? 10e Street and Number 10f Zin Code 10623 Crystal Falls Dr. 21742 U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White Specify: 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medicine Aid Nursing Home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph E. Hartle Hazel Pauline Lum 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Son) 16142 Rush Run Rd. Hagerstown, Md. 21740 *Terry Biser* 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) March 26, Smithsburg Cemetery Smithsburg, Md. 2008 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 12525 Bradbury Ave. MO1414 J.L. Davis Funeral Home Smithsburg, Md. 21783 AVIS 29a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) (holangis carein o 6 month Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underh in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of). IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1□ Yes 2☑No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

be executed

Box 68760,

P.0.

Records,

Division or Vital

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

a or

"natural", or items 23a edical Examiner must b

traumatic event, the Medical

injury or other

any

than

s 1 and 2 should be filed with Health and Mental Hygier tem 27 Is marked other th

permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is

72 hours after death

Maryland 21215-0036

Baltimore,

Director

Funeral

2

Completed

Be

၉

Examine Physician/Medical

burial-transit and attending physician the ase the signed by t page 2 s certificate has this

Completed 2 After t Certification: To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After the filled in by

completely

State Registrar

Medical

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

MA

29c. License number 041667 29d. Date signed (Month, Day, Year)

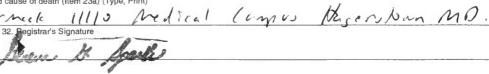
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

MClocneck 11110

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death **Physician** 2008 Gary Lee Boatman March 16, 1905 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Harford Memorial Hospital
Social Security Number 6. Sex. 7. de Grace 9. Birthplace (State or Foreign 8. Date of Birth Month, Day, Year) 02/11/1944 6. Sex 1 ☐ M 2 ☐ F . Age (In yrs. last birthday) **Funeral** Maryland Days Hours 215-42-5885 Yrs. 64 Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10h Counts 10d. Inside City Limits other traumatic event, the Medical Exandrer must be notified at 1 No 2 No Director Harkord Havre de Grace 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 704 Pulaski Highway Apt. 8 21078 U.S.A. Items 23a by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 5 White 1 ☐ Yes 2 1 No Specify: 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Security Security 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Glonn Boatman Doris Virginia Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Locust Court, Port Deposit, MD 21904 Lisa Thomas (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it eny injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State R.A. Ferris & Co., Inc. 3/18/2008 West Chester, PA 4 ☐ Donation 5 ☐ Other (Specify) Signatur fol Funeral Service Licensee 22. Name and Address of Facility Zeltman Funeral Home. P.A. 123 S. Washington St. Havre de Grace, MD 21078 Part1. Enter the disease, or complication shock, or heart failure. List only one can Approximate Interval Between Osset and Death hs that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use at each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ol). The law requires that the death certificate be executed Due to (or as a consequence of) Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome ol pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Yes 2 No 3 Probably 4 Unknown structive 24b. Were autopsy findings available prior to completion of cause of death? looked and tobacco 2200 1 Yes 26. Place of Death | Check only one Hospital: 1 Impatient 1 Tes 25No Other 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Statural 2 Accident 5 Pending investigation 1 TYes 2 □ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel artifying Physician: To the best of my knowledge, death consided at the time, data and place, and dualto the neural(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number D0036940 Them 23a) (Type, Print WYDOND MEMORUL HOSPITAL, SOI SOUTH AVENUE, HAVRE DE GRACE

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 25 rarch ROBERT LEON CLEMENTS, JR. /Medical unty of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner harles Lata Year | If Under 24 Hrs. If Under 1 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1√2 M 2□ F 78 212-22-5238 Director 6-7-1929 WASHINGTON, DC Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1√2 Yes 2□No Director MARYLAND CHARLES LA PLATA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? d other than "natural", or items 23a or a event, the Medical Examiner must be n 213 DEL RAY CIRCLE P.O.BOX 2291 20646 U.S.A. Funeral 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Tyes 2 No If Xes, Give NAT • GUARD 1 Yes 2 No Year or Date 3 4 7 - 4 9 1 Never Married 2 Married Specify Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CARPENTER HOUSE BUILDING thand 2 should be filed we Health and Mental Hygier them 27 is marked other th 12 laryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ROBERT L. CLEMENTS, SR. AGNES IRENE SIMMS ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:3 Department of Health at Important: If item 27 is any injury or other trau ADA CLEMENTS-SPOUSE LA PLATA, MD. 20646 P.O.BOX 2291 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages nent of I 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State TRINITY MEM. GARDENS 3-29-08 WALDORF, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MQ0479 RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 Muc Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ARDIAC **Physician** EN MINE /Medical Due to (or as a consequence of): Examiner CORONARY Sequentially had conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-trans Due to (or as a consequence of) P.O. Box 68760 attending physician Physician/Medical as the l IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 □ Pregnant at time of death 5 ☐ Other (specify) detached 9 I Inknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ RENAL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Dunknown Completed SHENSION 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No certificate 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ★ R/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No death. 2 Accident completely filled in by the 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier

Division or Vital Records,

8

(Check only one)

29b. Signature and title of centifier

State Registrar

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Paul, Mellon Ct. Suite 102 Waldorf, MD 20602

AShuiN atel Year) 2008 31. Date filed (Month, Day, 2. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 6:17 P MARCH 12, 2008 DANIEL PATRICK CARMODY /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WASHINGTON ADVENTIST HOSPITAL MONTGOMERY TAKOMA PARK Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 XM 2 ☐ F Director 008-22-1823 NOV. 9, VERMONT Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or items 23s or 28s-f show the Medical Examinar must be notified at 1∰Yes 2 No Director PRINCE GEORGES COLLEGE PARK 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? with 7018 WAKE FOREST DR. 20740 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. other than "naturel", or ite 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1952<u>–</u> 1958 1 ☐ Yes 2 X No Specify: Specify. 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+ permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygient Important: if item 27 is marked other tha any injury or other traumatic event, trainess. 12 CITY OF COLLEGE PARK CLERK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be PATRICK CARMODY McCANN ANNAMAE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3344 WHIPPLE HOLLOW RD., FLORENCE, VT. 05744 THOMAS P. CARRIGAN/NEPHEW 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 15 □ Other (Specify) CHAMBERS CREMATORY 3-17-2008 RIVERDALE, MD. 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cardiac Arrhythmia
Due to (or as a consequence of): Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Atheroscleratic Cardinascular Disease Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that iniliated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Completed by Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 □ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sign be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient ٢ 1 Inpatient 3□ DOA After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: d in by the 3 Suicide 6 Could not be determined 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 THomicide Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 57692 larch MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DREWRY 7600 CARROLL AVE., TAKOMA PARK, MD. 20912 WHITE, M.D. 31. Date filed (Month, Day, Year) 3 Registrar's Signature State 17 Registrar 2008

DHMH 17 Rev 1/2001

State Registrar

POOPAK BAKHTIARI, 31. Date filed (Month, Day, Year)

MD 9901 MEDICAL CENTER DR., ROCKVILLE,

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

32. Registrar's Signature MAR 1 8 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryla		ertificate of		, ,	ene	08	102	54
Ì	Physici /Medic		1. Decedent's Name (First, Middle, La Lewis F Clabaugh					2. Date of Death Month March	Day	Year 2008	3. Time of Dea 6:50 P	ath M
)	Examin		4a. Facility Name (If not institution, giv Frederick Memori			4b. City, Town, o	r Location of Deat ick	h	4c. County	of Death lerick	2	
	Funeral Director	-	210 07 0771		s. last birthday 91 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Nov • 27	Year) 916	9. Birthpla Counti Mary	ace (State or Fo	oreign
	e Maryland a-f show lified at	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Frederi		City, Town or L	ocation				10	ld. Inside City Li 1 ∐ Yes 2 Ş	
	th with th 23a or 28 ust be no	Funeral Directo	10e. Street and Number 13708 Hillside Av	enue		10f. Zip Code 21788	8	10	U.S.		ry?	
036	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or items 23a or 23a-f show ther, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	U.S. 13	. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		e - America k, White, e Whi	tc.	
1215-0036	I within 72 ho jiene. r than "natur the Medical i	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed) College (1-4or 5+)	(Giv life.	edent's Usual Occup e kind of work done DO NOT use retired rane Opera	during most of wo. d)	rking	16b. Kind of Bu		-	
Maryland 2	uld be filed Jental Hygi rked other tic event, tl	To Be Co	17. Father's Name (First, Middle, Last Elmer Clabaugh)				me (First, Middle, M Lewis	Maiden Surnam	ne)		
, Mary	is 1 and 2 should be filed thealth and Mental Hyg item 27 is marked othe other traumatic event,		19a. Informant's Name/Relationship (Don L. Clabaugh /	Son	6913	ling Address <i>(Street</i> Kelly Sto	ore.Road	, Thurmon	t, Mary	land	21788	
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other	1	20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	(y) B1	ue Rid	position (Name of ematory or other place ge Cemete)	ry 3/19	9/08 T	20c. Location - hurmont	, Mar	yland	
Ба	permit Depar Impor any in	w 3	21. Signature of Finderal Service Lice	Jailer /	6	22. Name and Addre OBERT E. I 15 EAST MA	AIN STREI	ET, THURM	ONT, MD	2178	38	
Z	Physician /Medical	87	23a. Part1. Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	iplications that causer the de one cause on each line. a. Due to (or as a conse		failure	ng, such as cardia	c or respiratory arre	est,		Approximate Interval Betwee Onset and Dea	en ith
/60,	ate be executed hysician and the burial-transit	I Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		t mm	pheumo tal stat	nia tus		days			
.O. Box 687	ath certific attending p for use as f	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of	etal death 3	□Ectopic pregnanc	у		23d. Dat	e of deliver	ry Day Yea	ır
7	w requires that the de been signed by the a should be detached i	by	Part II. Other significant conditions	contributing to death but not re	esulting in the	underlying cause giv	ven in Part I.				e cause of deat	
al Hecords,	The law ate has b page 2 sl	Completed						y ned?	orior to con death?	osy findings avanpletion of caus	ailable se of	
n or vital	ng Phy fter this ineral d	on: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending	ner: 4□ Nursing I ry at rk?	ath <i>(Check only on</i> - Home 5 ☐ Reside 28d. Describe ho	ence 6 □Oth)				
DIVISION	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	e 280 Place of injury - At	home, farm, s cify)		Yes 2 ⊡No	28f. Location (St. City or Town		er or Rural	Route Number	r,
	the Hospit in 24 hour the Funera	Medical ((Check only 2 Medical Examone)	nysician: To the best of my k miner: On the basis of exami and manner stated.		investigation, in my	opinion, death occ	curred at the time, d	ate and place,	and due to	the cause(s)	
	To t Com	Z	29b. Signature and title of certifier	R. Rengen			65839	2	3/16	o (Month, L	Day, Year)	
	3		30. Name and address of person who Rohan R. Rengen,				Frederic	ek, MD 21	701			

State

32. Registrar's Signature MAR 1 8 2008 > See & Special Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 = For State Registrar	,	Ce	rtificate of		F	leg. No. 2008	8 10255
Physic	ian	Decedent's Name (First, Middle, Last) Nancy Lee Cunni	ngham				2. Date of Dea Month March	Day Year	3. Time of Death
/Med	ical	4a. Facility Name (If not institution, give s	street and number)		4b. City. Town, o	r Location of Death	1	4c. County of Dea	15:38 P M
Exami	ner	Frederick Memor		1	Frede			Frederic	
Funera Directo		210-30-0902	-X-	yrs. last birthday, 5 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day March	9. Bir 29,1942 Ma	thplace (State or Foreign ountry) cryland
and and		Usual Residence of Decedent 10a. State 10b. County	10c	. City, Town or L	ocation				10d. Inside City Limits
Maryl -f sho fied a	ţ	Maryland Frederi	.ck	Br	unswick				Y∭ Yes 2 □ No
th the or 28a e noti	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	ountry?
ath wi	la	408 East D. Stree			2171			United S	
DEBILLINOTE , IMBRYIBING Z1Z13-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	n U.S. 13.	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2K No		pecity Yes or No- o Rican, etc.)		
"natu	letec	15. Decedent's Educ (Specify only highest grade	cation completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wor	rking	16b. Kind of Business	/Industry
G ZIZI filed within Hygiene. other than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	me.	Homemake	,		Own H	ome
be filed ntal Hyging of other event, t	Be C	17. Father's Name (First, Middle, Last)					ne (First, Middle,	Maiden Surname)	
Viar Menta Menta arked atic ev	일	William Delauter				Nellie	Linton		
Mary d 2 sho th and 7 is ma trauma		19a. Informant's Name/Relationship (Ty)	ŕ		•			r, City or Town, State,	,
1 and 1 and Health em 27		Roxanne Falconer		b. Place of Disp	osition /Name of		Brunswic Date	2k, MD 2171 20c. Location - City or	
SAILLIMOR Dermit. Pages Department of mportant: If it any Injury or once.		1 ☐ Burial 2 ☐ X remation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		Stauffe	matory or other pla Cremato 2. Name and Addre	ry 3/14	1/2008	Frederick	, Maryland
permi Depal Impol		21. Signature of Funeral Service License	Stauller	, '		,		er Funeral unswick, MD	
* -		23a. Part1. Enter the disease, or compli- thock, or heart failure. List only or	cations that caused the	leath. Do not er					Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Due to (or as a cor	e 06	tructive	Pulmen	am Dig	cose	Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a cor	sequence of):			Ö		
		Sequentially list conditions,	. Due to lor as a cor	se uence of :					
cuted d ansit	i i	cause. Enter Underlying Cause (Disease or injury that initiated events							
e exection and an and urial-tr	Ex	resulting in death) Last	Due to (or as a cor	sequence of):		-			
oertificate be executed iding physician and se as the burial-transit	Medical Examiner	d	-						
death cel	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 27 No 9 □ ∪nknown	3c. If yes, outcome pf pro 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	⊒Ectopic pregnanc ⊒ Other <i>(specify)</i> _	у		23d. Date of de Month	livery Day Year
that the led by detac		Part II. Other significant conditions cor	tributing to death but not	resulting in the u	ınderlying cause giv	ven in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
rdS quires in sign uld be	d by	Lang Mass					4K/A	′es 2□No 3□P	robably 4 Unknown
The law requires that the ate has been signed by the bage 2 should be detached.	Completed						24a. Was a		utopsy findings available completion of cause of
The take he page	l E						perfo	rmed? death? 2 No 1 ☐ Yes	·
Or VILAT Physician: 1 rthis certificat ral director, pa	Be	25. Was case referred to medical examiner?	lospital:		Ott	or.	ath (Check only o		
Phys r this gral dir	ا <u>:</u>	1 ☐ Yes 2 € No 27. Manner of Death	28a. Date of Injury	2 ER/Outpatie	III JUDON	4 L Nursing F		lence 6 Other (Speciow injury occurred	ecify)
SION tending leath. tor: Afte the fune	ation	Natural 5 Pending investigation	(Month, Day Yea	r) Injury		rk?]Yes 2∐No			
al or Atte after des in Director	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - physical building, etc. (Sp.	At home, farm, st pecify)	reet, factory, office		28f. Location (S City or Tow	Street and Number or Fi n, State)	ural Route Number,
To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	Medical C		sician: To the best of my ner: On the basis of exal and manner stated.						
To th withir To th	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signed (Mon	th, Day, Year)
		MTolino	MD		M25	1610		3/12/08	
1		30. Name and address of person who co		/		21702		!	
S	ate	31. Date filed (Month, Day, Wear)	32. Registrates S		A sept o	/			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			1 - For State Registrar	State of		nd / Depa		t of H	lealth a	and M		giene	3	102	56
a.	*: * ;	ę	Decedent's Name (First, Middle, L.)	ast)			timout	0 0, 1	Joann	-	2. Date of Dea	Reg. No. ath		3. Time of D	Death
	Physici /Medi		Geneva Cheel							l ₁	Month March	13,	2008	10:1	5r ^M
	Examir		4a. Facility Name (If not institution, g		ver)		4b. City,	Town, or	Location of	of Death			ounty of Deat		
			Laurelwood (Care			EJ	Lkto	n			Ce	eci1		
	Funeral Director		162-28-0582	Sex 7. 1 □ M 2 10 F	Age (In yrs. 95	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours		8. Date of Birt (Month, Day July I	h y, Year) 7,19	9. Birtl Co	nplace (State or untry)	Foreign A
_	pue *		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ity. Town or Lo	cation							10d. fnside City	Limits
	Manyll f sho	ō		ci1		E1kt								Yes 2	
	28a	Director	10e. Street and Number				10f. Zip	Code				10g. Citize	en of What Co	untry?	
	h with	Die	100 Laurel	Drive				219	21				U.S.A		
	deat	Funeral	11. Marital Status	12. Was Decede	ent Ever in U	J.S. 13.	Was Deced	dent of Hi	spanic Ori	igin? (Spe	cify Yes or No- Rican, etc.)	. 14	4. Race - Ame		
9	or its	F	1 Never Married 2 Married	1 Yes 2			1 ☐ Yes				nican, etc.)		Black, White Specify: W	hite	
003	hours after death with the Maryland tural', or itema 23a or 28a-f show al Exercinal for cotified at	d by	3 Widowed 4 Divorced	Year or Date	os:										
5	"nat	iete	15. Decedent's l (Specify only highest g	ducation rade completed)		16a. Dece	dent's Usua kind of woi DO NOT us	rk doné d	during mos	t of workir	ng	16b. Kind	d of Business/I	ndustry	
21215-0036	within iene.	Completed	Elementary/Secondary (0-12)	Coflege (1-4	or 5+)		lomen		,			н	ouseho	1 d	
ğ	e filed Il Hygie other	a	17. Father's Name (First, Middle, Las	it)						er's Name	(First, Middle,				
lar	uld be Mental irkad o	To B	William Sut	phin					A1	Lma 1	Harman	ı			
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23e or 28e-f show other traumatic event, the Medical Exercities must be rectified at		19a. Informant's Name/Relationship			122	ng Address	(Street a	and Numbe	er or Rura	Route Numbe	or, City or	Town, State, Z	ip Code)	
	and ealth m 27		Rebecca Ledfor	cd/Grand		A STATE OF THE PARTY OF THE PAR			ains					20137	,
Baltimore,	ges 1 it of H if ite or oti		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3.	Removal from Sta	ate '	Place of Dispo cemetery, crer	natory or o	ther place		(arc)	ate h 18,	20c. Loc	ation - City or	Town, State	
ţ	t. Pa rtmen rtent:		4 Donation 5 Other (Spec	* *	Mt	. Zior	-		ry	200		Peac	ch Bot	tom, PA	L
Bal	permit. Pages 'Department of H Important: If Ite any injury or ot		21. Sign ture of Fun and Service Lice	ensee		22	Name an Andr				Funera	1 H	ome		
			23a. Part1. Enter the disease, or con	notications that cau	sed the dea	th. Do not ent	259	E •	Main	St.	E1k	ton,	, MD	21921 Approximate	
	N		shock, or heart failure. List online Immediate Cause (Final	y one cause on eac	n iine.					cardiac of	i iospiiatory ai	1031,	:	Interval Betwee	
1	Physician /Medical		disease or condition resulting in death)	a	as a consec	LE 70	· (N.	21 15	-						
	Examiner		- 1	Dae (0 (0)		tuence on).									
100	To Both N	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or	as a consec										
T	cuted nd ransit	Examiner	triat initiated events	c											
,092	be executed icien and burial-transit	Ë	resulting in death) Last	Due to (or	as a consec	quence of):									
876	e ys	dicai	•	d											
89 x	ding	Physician/Med	IF FEMALE:	23c. If yes, outcome	me of pregn	ancy									
Вох	atten atten I for u	clan	23b. Was decedent pregnant in the past 12 months?	1☐Live birth	1 2 ☐ Feta	aideath 3⊑	Ectopic pro					23	d. Date of defi Month	very Day Ye	аг
o.	the d y the ached	ıysi	1 ☐ Yes 2 ☑No 9 ☐ Unknown	9□ Unknow			3011107 (3)	oo.iy/							
<u> </u>	The law requires that the death certifica are has been signed by the attending ph page 2 should be detached for use as th	by Pi	Part II. Other significant conditions	contributing to deat	h but not res	sulting in the u	nderlying ca	ause give	n in Part I.		23e. Did to	bacco use	e contribute to	the cause of dea	ath?
rd	aquire en sig uld b	edt									1 □ Y	'es 2 🗆	No 3 ☐ Pro	bably 400n	known
၁၁	law re as be 2 sho	plet									24a. Was autop	an	24b. Were au	topsy findings av	ailable
Ě		Completed									perfor	med? 2□Ne	death?	ompletion of cau 22 No	JSO OI
Vital Records,	Physician: this certific ral director,	Be	25. Was case referred to medicat examiner?								(Check only of	пе)			
	Physic this c	P_	1 Yes 2 No	1		ER/Outpatien		A Othe	A Nu		ne 5 🗆 Resid			ufy)	
Division of	Jing J After funer	lon	27. Manner of Death 1. Naturaf 5 Pending		Day Year)	28b. Time of Injury	М 2	8c. Injury Work	?		8d. Describe h	ow injury	occurred		
<u> S</u>	l or Attending after death. Director: After in by the fune	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not	be 390 Blace of	fniury - At h	ome, tarm, str			/es 201		8f Location (S	treet and	Number or Ru	ral Route Numbe	
<u>S</u>	after after Dire	Certification:	4 Homicide determine	buifding,	etc. (Specia	fy)	coi, ractory	, once			City or Tow		710/1100/ 01 /10	TAT TIGBLE TVALLE	,
	To the Hospitel or Attenwithin 24 hours after deation to the Funaral Director: completely filled in by the		29a. Certifier 12 Certifying F	hysician: To the be	est of my kno	owledge, death	occurred a	at the tim	e, date an	id place, a	nd due to the o	ause(s) a	nd manner as	stated.	
	n 24 n 24 he Fu	edical	(Check only 2 Medical Exa	miner: On the basis	s of examina	ation and/or inv	estigation,	in my op	oinion, deal	th occurre	d at the time, o	date and p	lace, and due	to the cause(s)	
	To the I within 2 To the I complet	Σ	29b. Signature and title of dertifier				29c	License	number		2	29d. Date	signed (Month	, Day, Year)	
			Hollan	~				540	73		/	7 M	AR 08		
			30. Name and address of person who	completed cause of			Print)			-			100		
	2		31. Date filed (Month, Day, Year)	MD 817		ethmus		2	NEW	2645	re l	E	1972	<i>D</i>	
3	Sta Registr		MAR 1 8	2008	due	ature A	Sand .								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					State	oi ivia	iryiand				neaith and <i>Death</i>	Mental H	/gien Rea. N	000	18	1025	7
			1. Decedent's Name	(First, Middle,	Last)							2. Date of D	eath	- C '	3 14	3. Time of Dea	th
	Physicia /Medic		Leo V. (Cornell								Month	20		Year 08	3:50 1	Р.М.
1	Examin		4a Fecility Name (If		give street and n	umber)				T	4b. City, Town, o	r Location of Dea	th 4	c. County	of Death		
			0ak1and	Nursing	& Reha	bili	tatio	on			0aklan	d		Gar	rett		
	Funeral		5. Social Security Nu		. Sex			st birthday)	If Und	er 1 Year Days	Hours Min	n. (Month, D	ay, Year	r)	9. Birthpi Coun	lace (State or For	reign
	Director		235-22-3		1 M 2□ F	93		Yrs.				June	21,	1914	Wes	t Virgi	nia
	pue *	ŀ	Usual Residence of 10a. State	10b. County			10c City	Town or Lo	cation						10	0d. Inside City Lir	mits
	ier death with the Marylen flems 23s or 28s-f ehow her must be notified at	5													"	1⊠Yes 2□	
	28.9-	Director	MD 10e. Street end Num	Garrett			0ak1	Land	106.7	ip Code			10a C	itizen of V	What Coun	tru?	
	with a or	5	706 E. A		root					550				ited		•	
	leath	era	11. Marilel Slatus	Transi	12. Wes De	cedent E	ver in U.S.	13. V	_1		lispanic Origin? (Specify Yes or N			- America		
)20	72 hours efter death with the Marylend natural', or items 23s or 28s-f ehow disal Examiner must be notified at	by Funeral	1 XNever Marrie		Armed F	Forces? 2 ☐ No live	0	1			an, Mexican, Pue Specify:	(Specify Yes or Norto Rican, etc.)			k, White,	etc.	
21215-0020	2 hou	8		15. Decedent's	Education		WWII	16a Deced	lent's Us	ual Occur	oation	-	16b. I	Kind of Bu	Whit siness/Ind		
215	hin 72	Completed	(Special Special fy only highest g	rade completed College			(Give life. L	kind of w	ork done use retire	during most of w d)	orking						
2	d within jiene. r than "	E	12	luary (U-12)	College	(1~401.54	"	Cus	stodi	lan				Pub	lic S	choo1	
bu		Be	17. Father's Name (/	First, Middle, La	st)				-		18. Mother's Na	ame (First, Middle	e, Maide	n Sumam	e)		
Maryland	Vents	2	Taylor (Cornell							Ida Yos	st					
lan	and I		19a. Informent's Nar	me/Relationship	(Type, Print)			19b. Mailin	g Addres	ss (Street	and Number or F	Rural Route Num	ber, City	or Town,	State, Zip	Code)	
	end alth		Vera Sto	nebrake	r, P.O.	Α.					Elk Gard	den, WV		267	17		
ore	iges 1 if item or oth		20a. Method of Dispo 1 X Burial 2 □		□Removal from	State	20b. Plac	ce of Dispos netery, cren	sition (Na natory or	ame of other pla	ce)	Date	20c. l	ocation -	City or To	wn, Slate	
Ē	nit. Pages ertmant of ortant: If it injury or o		4 ☐ Donation			· Otato	I.0.	O.F.	Ceme	etery		3/25/08	E1	k Gar	rden,	WV	
Baltimore,	Depert Meport Mport Injuly Inj		21. Signature of Fun	eral Service Lic	ensee			22	Name a	nd Addre	Burdeel	k Funera	1 Ho	me 1	РΔ		
ш	20E 3 8		Kum	eres)	Muei	Tur						et, Kitz				538	
			23a. Part1. Enter the shock, or heart	e disease, or co	mplications that	caused t	he death.	Do not ente	er the mo	de of dyir	ng, such as cardi	ac or respiratory	arrest,	all wastered	1	Approximate Interval Between	
7	Physician				· S NWALTH											Onset end Death	1
ı	/Medical Examiner		Immediate Cause (F disease or condition		RU	pto	tree	2 al	bdo	mei	Nal a	eostic 0	thei	left	en	8hr	/
		_	resulting in death)		0	0	Due to (or a	s a conseq	uence of):		eostic c		3	1	1000	
	bei ist	edical Examiner			b. ab	don	WNa	l a	240	C 0	aneur	ym			<u> </u>	1944	
	xacu al-tra	Xar	Sequentially list conditions in the sequentially list conditions in the sequential seque	ditions, nediate		Ja	ue lo (or a	s a consequ	uence of):		,			į		
68760,	tificete be executed g physician and as the bunal-transit	a	cause. Enter Underl Cause (Disease or in that initiated events	ying njury	c. a	100	109	screi	DU	سدا					(gear_	-
687	ficete physics the	8	resulting in deeth) La	ast		D	ue to (or a	s a consequ	uence of)	:					!		
-	certi	2			d										_		
Ď	d for	2	Part II. Other elgnific	ant conditions	contributing to d	loath hut	not resulti	na in the un	rderlying	cause niv	ren in Pert I	23h Dio	tobacc	o use con	tribute to	the cause of de	ath?
Ö	by the	l ys	- O-	0 . 0)	/	10	ig at the tal	i	duso gr	4		/	2□ No	3∏ Prob		
S,	s tha	6	accor	roll	m, l	usp	10 Th	yroi	a_{-t}	dei	nenta	- /				HI	
Division of Vital Records, P.O. Box	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. To the Funeral Director: After this certificate has been signed by the ettendin completaly filled in by the funeral director, pega 2 should be detached for use	Completed by Physician/N						0				24a. Wa perl	s an auto	opsy	ava	ere autopsy findin allable prior to appletion of cause	_
ခ္	law law las b	<u> </u>													of c	leath?	1
<u>~</u>	cate l	5										10	Yes 2	2Å No	10]Yes 2□No	
<u> </u>	Iclan Sertifi Pector	ng	25. Was case referre examiner?		Hospital:					Oth	or f	eath (Check only					
ð	Physical direction	<u> </u>	1 ☐ Yes 2 ☐ XN 27. Manner of Death	0	28a. Dele	Inpatient	- 7	NOutpatient Bb. Time of		OA	Nursing	Home 5 ☐ Res 28d. Describe				<u>)</u>	
Ö	After fune		1 Natural	5 Pending investigati	(Mor	nth, Dey	Year)	Injury	м	28c. Injur Wor 1 □	k? Yes 2∐No	200.0000.00		y 0000			
IS.	Attended of deat	I Ca		6 Could not	be 28e. Place	e of Injur	y - At home	e, farm, stre	et, facto			28f. Location	(Street a	ınd Numbe	er or Rura	l Route Number,	
\leq	al or safte		4 ☐ Homicide	GOLOMMIC	build	ling, etc.	(Specify)					City or To	wn, Stai	le)			
	hours hours aners ily fille											ce, and due to the					
	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completally filled in by the funer	medical Certification:	one)			nner state		. ear CV UF III V				curred at the time					
	To Too	2	29b. Signature and ti	tle of certifier	- 1	/	•	10	29	c. Licens	e number	1	29d. Da	ate signed	(Month, L	Day, Year)	
	3		Piller	Here	Ud	Ve	Ru	11)		0266	30	<u> </u>	-21	-20	200	
	+1 1	7	30. Name end eddres	s of person who	completed cau	se of dea	ath (Item 2	3a) (Type, F	Print)	realt	1, to D		1	2	1	1 2153	-
			margar.	era	caiser	LIC	's Signatur	014	yal	sell	mizum	ry , wo	W.	ans	c, M	X XIDS	10
	State		31. Date filed Month	Day, Year)	2008	registrar	s orginatur	As la	V Sangar	200		/					

DHMH 16 Rev 6/95

W

fer in

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural" --- any injury or other traumatic events.

Examiner law requires that the death certificate be executed ed by the attending physician and detached for use as the bunal-tran Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March 15, 2008 10:20 AM Allen Russell Cutter 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Frostburg Allegany Frostburg Village Nursing Home | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 M 2 □ F Maryland 91 216-05-2958 November 17, 1916 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 □ No Director Lonaconing Allegany Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21539 15813 Lower Georges Creek Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. 1 ☐ Yes 2 🔏 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 💆 No Specify: Specify ģ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Fibers Spinning 10 O 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter Cutter Hannah Russell 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14500 Flint Road SW, Midland, Maryland, 21542 Richard Cutter - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition March 19, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Sunset Memorial Park 2008 Cumberland, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Eichnorn-McKenzie Funeral Home P.A. 21. Signature of Funeral Service Licensee McKeyne ٤. 8 East Main Street, Lonaconing, Maryland 21539 23a. R. Ht. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CHRONIC OBSTRUCTIVE LUNG DISEASE 5 years /Medical Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4MNursing Home 5 Residence 6 Other (Specity) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA ۲ 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No M 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MARCH 17, 2008 1 26907 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

19

725

32. Registrar's Signature

M.D

Bishop walsh Road, Cuntor/news, Mary/nud 215002

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician March 15, 2008 Anne С. DeAtley 6:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Corsica Hill Nursing Home Centreville Queen Annes 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday)
73 vre 8. Date of Birth Nov. 1934 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2**X**XF 578-44-1520 Washington, DC Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at Queen Annes 1 ☐ Yes 2XXNo Maryland Director Centreville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 205 Armstrong Avenue 21617 USA "natural", or Items 23a filed within 72 hours after death Hygiene. other than "natural", or Items 23 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 21215-0036 White 1 ☐ Yes 2 MNo Specify: þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 Is marked other the any Injury or other traumatic event, the any Injury or other traumatic event, the ones. Statistician U.S.Air Force Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cross Elizabeth O'Connor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8482 Colony Circle Faston, Maryland 21601 John DeAtley / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Resurrection Cemetery 03/18/2008 Clinton, Maryland 4 □ Donation 5 □ Other (Specify) 22 Name and Address of Facility George P. Kalas Funeral Home P.A. 21. Signature Funeral Sorvice License ale 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one quiuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ardiac arres Physician /Medical Due to (or s a consequence of): Examiner near Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed burial-trar Due to for as a consequence of) P.O. Box 68760, physician Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Po in the past 12 months? 1 ☐ Yes 2 No Month Day 5 ☐ Other (specify) 4□Pregnant at time of death ed by the a 9 Unknown as been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy page performed? Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? funeral director. Medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Mapner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day Year) Natural To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 ☐ Accident the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

State

completely

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

eath (Item 23a) (Type, Print) 610 Dutchmans Line, Easton, MD 2160)

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

			State of Maryland /	Department of He Certificate of De			0000 10001
Est.	w	-	Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Di		Reg. 2. Date of Death	No. 3. Time of Death
	Physicia /Medic		RUBY O'BRIEN			March	15, 2008 5:30 A M
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Lo			4c. County of Death Frederick
- 17	Company Medical	18	106 Dogwood Avenue 5. Social Security Number 6. Sex 7. Age (In yrs. last b)	Thurmont irthday) If Under 1 Year] I		8. Date of Birth	Birthplace (State or Foreign
	Funeral Director		240-48-5828 1 M 2 T F 77	Yrs. Months Days	Hours Min.	Oct. 4,	ear) Country)
	pug 🔉		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow	wn or Location			10d, Inside City Limits
	Manyla f sho	tor	Maryland Frederick Thurm	ont			1 ☐Yes 2 ☐ No
	r 28a- notif	Directo	10e. Street and Number	10f. Zip Code		10g	. Citizen of What Country?
	th with 23a o 1st be	al D	106 Dogwood Avenue	2178	8		U.S.A.
	be filed within 72 hours after death with the Maryland de Hygiene. de other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ Mo	13. Was Decedent of Hisp If Yes, specify Cuban,	oanic Origin? (Spec Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
21215-0036	ours af	by	3 Mathematical If Yes, Give Year or Dates:	1 ☐ Yes 2 🛣 No	Specify:		Specify: White
2 2	72 hc "natu dical	Completed	15. Decedent's Education (Specify only highest grade completed)	 Decedent's Usual Occupating (Give kind of work done dur life. DO NOT use retired) 	on ring most of workin	ng 16	b. Kind of Business/Industry
121	within ene. than he Me	Jup	Elementary/Secondary (0-12) College (1-4or 5+)	Sales			Meat Market
S O	filed Hygi other ent, tl	Be Co	17. Father's Name (First, Middle, Last)		8. Mother's Name	(First, Middle, Ma.	
lan I	ould be Mental arked o atic eve	To B	Arthur Reese	1	Margaret	Turner	
Maryland	2 short and is m	·	1 121				City or Town, State, Zip Code)
<u>ق</u>	s 1 and f Health item 27 other to		20a. Method of Disposition 20b. Place comment	of Disposition (Name of tery, crematory or other place)	D	ate 20	c. Location - City or Town, State
Ē	Pages nent of I int: If its ury or o			teran Cemeter		08 C1	neltenham, Maryland
Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Ucens				RAL HOMES, P.A.
	1000		23a. Parti. Enter the disease, or coappleations that outsed the death. Do shock, or heart failure. List only one cause on each line.				ONT, MD 21788 Approximate Interval Between
	Physician		Immediate Cause (Final	ν			Offset and Death
	/Medical		disease or condition resulting in death) a. Due to (or as a consequence		1,001		19801
	Examiner	<u>_</u>	Sequentially list conditions, b. Due to (or as a consequence	of):			
	nsit	Examiner	cause. Enter Underlying Cause Disease or Injury	, or).			
a î	execu an and rial-tra	Exal	that initiated events resulting in death) Last c	e of):			
58760,	icate be executed physician and s the burial-transit	edical	d				
_			IF FEMALE: 23c. If yes, outcome pf pregnancy	· · · · · · · · · · · · · · · · · · ·			001 0 11 11 11
Box	The law requires that the death certificate has been signed by the attending lage 2 should be detached for use as	Physician/M	in the past 12 months?	th 3 Ectopic pregnancy 5 Other (specify)			23d. Date of delivery Month Day Year
Ö	t the d by the ached	hysi	1 Yes 2 No 9 Unknown 9 Unknown				
S, T	w requires that the de been signed by the should be detached	by P	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given	in Part I.		cco use contribute to the cause of death?
ord G	require sen siç rould b		Diobetes mellitus			1 ☐ Yes	2MNo 3 Probably 4 Unknown
Records,	e law r	Completed	Hypertension.			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of death?
	n: The icate r, pag						No 1 Yes 2 No
Vital	slciar certif	o Be	25. Was case referred to medical examiner? 1 Yes No Hospital: 1 Inpatient 2 FR/C	Othor	26. Place of Death · 4 □ Nursing Hor		ce 6 Other (Specify)
0	ding Physician: The lav n. After this certificate has funeral director, page 2	-	27. Manner of Death 28a. Date of Injury 28b.	. Time of 28c. Injury a		28d. Describe how	
<u>io</u>	arth. or: Aftu	atio	1 Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation		es 2 🗆 No		
Division or	or Attender de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, the building, etc. (Specify)	farm, street, factory, office	2	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certifics completely filled in by the funeral director, p.		29a. Certifier (Check only CertifyIng Physician: To the best of my knowledge CertifyIng Physician: To the best of my	ge, death occurred at the time	e, date and place, a	and due to the cau	ise(s) and manner as stated.
	the H hin 24 the F mplete	Medical	one) and manner stated.	29c. License r			
	vit To		29b. Signature and title of certifier			290	I. Date signed (Month, Day, Year)
,	0		30. Name and address of person who completed cause of death (Item 23a)	DST	343		11708
1	L		65 C Tham and Than 3	7).	Forda	n's De n	ND 21902
Ü	Sta	ite	31. Date filed (Month, Day, Year) 32. Register's Signature	20 1 1			-1/-

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2. Date of Death Day March 15, 2008 7:30 PM4c. County of Death 4b. City, Town, or Location of Death Crisfield Somerset If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Hours February 7, 1924 Pennsylvania 10d. Inside City Limits 1 ☐ Yes 2 No Crisfield 10g. Citizen of What Country? 21817 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry High School Cafeteria 18. Mother's Name (First, Middle, Maiden Surname) Theresa Daniello 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5392 S. Pomfrett Road - Crisfield, MD 21817 20c. Location - City or Town, State 3/19/2008 Sunnyridge Memorial Park Crisfield, MD 22. Name and Address of FacilityBRADSHAW & SONS FUNERAL HOME 306 W. Main Street - Crisfield, MD 21817 23a. Part1. List only one cause on each line. Approximate Interval Between Onset and Death Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician/Medical IF FEMALE If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIVERTICULITIS 1 ☐ Yes No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 48098 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

been signed by the attending physician and should be detached for use as the burial-tran Division or Vital Records, P.O. Box 68760. To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

Registrar

State

31. Date filed (Month, Day, Year)

MAR 1 8 2008

Vijay Karumbunathan, M.D. - 201 Hall Highway, Crisfield, MD 21817

32. Regulari's Signature

Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burdal-transit and the funeral director, page 2 should be detached for use as the burdal-transit and the funeral director.
	Phy	sicia
	/M Exa	edica mine
Division or Vital Records, P.O. Box 68760,	cian: The law requires that the death certificate be executed	ritificate has been signed by the attending physician and stor, page 2 should be detached for use as the burial-transit

Funeral Director

	For State Registrar	State 0	i iviai ylatt	-	artment of F rtificate of				Reg. No.	2008	10263
ian	1. Decedent's Name (First, Middle,	Last)						2. Date of De Month	eath Day	Year	3. Time of Death
cal	Rena Hunt		lkerson					March			2:25 a ^M
ner	4a. Facility Name (If not institution,	give street and nui	mber)		4b. City, Town, o	r Location of	of Death		4c. C	County of Death	
	5. Social Security Number	Drive B. Sex	7. Age (In yrs. I	last birthday)	Sil:	ver Sj		8. Date of Bi	rth	Montgo 9. Birtho	mery lace (State or Foreign
	240-40-1848	1□M 2∏F	80	Yrs.	Months Days	Hours	Min.	(Month, Da reb. 28	ay, Year)	Coun	th Carolin
	Usual Residence of Decedent							CD. 20	, 1		
_	10a. State 10b. County		10c. City	, Town or Lo	cation					1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
Director	Maryland	Montgom	ery	Sil	ver Spri	ng			40 000		
	10e. Street and Number				10f. Zip Code				rog. Gilizi	en of What Cour	ury:
Funeral	207 Lexington 11. Marital Status		edent Ever in U.	S. 13.	20901 Was Decedent of F	lispanic Ori	igin? (Spe	ecify Yes or No	o- 1-	USA 4. Race - Americ	an Indian,
2	1 ☐ Never Married 2 ☐ Marrie	Armed Fo d 1 ☐ Yes If Yes, Gi			If Yes, specify Cub	an, Mexica	n, Puerto I	Rican, etc.)		Black, White,	
2	3 Widowed 4 Divorced	Year or D	vers:		1 ☐ Yes 2☐No	Specify:				Specify: Whi	te
erec	15. Decedent's (Specify only highest	Education grade completed)		(Give	dent's Usual Occup kind of work done	during mos	st of worki	ng	16b. Kin	d of Business/Inc	dustry
Completed	Elementary/Secondary (0-12)	College (lite.	DO NOT use retire						
	17. Father's Name (First, Middle, La		4	<u></u>	Homei	naker 18. Mothe	er's Name	(First, Middle	. Maiden S	Own Surname)	Home
0 0	Harvey Dean Hu	,						Trull		,	
2 │	19a. Informant's Name/Relationship			19b. Maili	ng Address (Street	and Numb				Town, State, Zip	Code)
	John F. Fulker	son, Jr.	/Son		207 Lexi	ngton	Driv	e, Sil	ver S	Spring,	MD 20901
1	20a. Method of Disposition				osition (Name of matory or other pla	ce)		ch 17,	20c. Loc	eation - City or To	own, State
	Hurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			rklawn	Memoria	l Parl		•	Rockv	ville,Ma	ryland
	21. Signature of Funeral Service Li	a Col	e	F	2. Name and Addre rancis J 00 Unive	. Col:	lins	Funera	1 Hom Silve	ne Inc. er Sprin	g, MD 2090
	23a. Part1. Enter the disease, or o shock, or heart failure. List o	mplications that on	caused the deatl							-	Approximate Interval Between
	Immediate Cause (Final disease or condition	_	t Cance:	r						6	Onset and Death Months
	resulting in death)	a	(or as a conseq							-	
_	Sequentially list conditions,	b	,								
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or mount)	Due to	(or as a conseq	uence ot):							
Yal	that initiated events resulting in death) Last	c	(or as a conseq	uence of):							
g Za		d									
_		- U.									
M/M	IF FEMALE: 23b. Was decedent pregnant		tcome pf pregna birth 2 DFeta		⊒Ectopic pregnanc	v			2	3d. Date of deliv	
sician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of d		Other (specify)					Month	Day Year
7	9 ☐ Unknown Part II. Other significant condition	an nontributing to d	loath but not roo	ulting in the u	undorlying cauco gi	on in Port		23a Did	tobaccous	se contribute to t	he cause of death?
2	Part II. Other significant condition	is contributing to d	leath but not les	uning in the t	indenying cause gr	ven in r ant			Yes 2		bably 4 □Unknown
pieted					·. ·		-				
E E			·						s an opsy formed?	prior to co	opsy findings available empletion of cause of
3							4	1□ Yes	2 XNo		2□ No
o pe	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2	FR/Outpatia	nt 3 DOA Oti	ner:		n (Check only		3 □Other (Speci	f ₁ ()
	27. Manner of Death	28a. Date	of Injury	28b. Time	of 28c. Inju	ry_at		28d. Describe			iy)
0	Natural 5 Pending 2 Accident investiga		nth, Day Year)	Injury		rk?]Yes 2□]No				
Certification	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ZOU. Flaut	e of injury - At ho	ome, farm, st	reet, factory, office			28f. Location City or To	(Street and own, State)	d Number or Run	al Route Number,
Se	, Livinoido	Julia		,,			- 4				
edical	29a. Certifier 1 🔀 Certifying (Check only one)	Physician: To the examiner: On the band man	e best of my kno casis of examina mer stated.	wledge, dea ition and/or i	th occurred at the to estigation, in my	ime, date a opinion, de	and place, eath occur	and due to the red at the time	e cause(s) e, date and	and manner as a place, and due t	stated. to the cause(s)
Me	29b. Signature and title of certifier				29c. Licen	se number			29d. Date	e signed (Month,	Day, Year)
			1		200	43	75		3-	14-00	
	30. Name and address of person w	_								2000	
	Cheryl Ayleswor			aturo -	ity Blvd	. Wes	t, Wh	neaton,	MD 2	20902	
te ar	31. Date filed (Month, Day, Year) MAR 17		Registrar's Signa	A da	will						
141	MILII/ T I		Markey N	100							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State	of Maryland / Depa	artment of Health and M	ental Hygier	renns inast
			State Registrar	Cei	rtificate of Death	Reg.	
ı	Physicia	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year 3. Time of Death
	/Medic	al	HELEN ALLENE	FELTON	4b. City, Town, or Location of Death	21	4c. County of Death
	Examin	er	4a. Facility Name (If not institution, give street and Oakland Nursing & F		Oakland		Garrett
Ŧ	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign
L	Director		234-07-3633 ^{1□ M 2} ₽	F 90 Yrs.	Months Days Hours Min.	12/15/1	917 WV
	pu s		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits
	Maryla f sho	ō	WV Preston	Terra A	Alta		1 □ Yes 2 □ No
	r 28a	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?
	th with	ai D	438 Park Street		26764		U.S.
	eme er tra	Funeral	Armed	Decedent Ever in U.S. 13. d Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	s afte	by Fu	If Yes	es 2 XNo , Give or Dates:	1 ☐ Yes 2万 No Specify:		Specify: White
8	filed within 72 hours after death with the Maryland Hygiene. other than "neturel", or lleme 23a or 28a-f show ent, the Musical Exteriment out the notified at	edk	15. Decedent's Education	16a Dece	dent's Usual Occupation	16b	. Kind of Business/Industry
75	hin 72	piet	(Specify only highest grade complet Elementary/Secondary (0-12) College	(Give life.	kind of work done during most of worki DO NOT use retired)	n <i>g</i>	
7	ed wit	Completed	8th		Homemaker	(First, Middle, Maid	Domestic
ī	be file	Be	17. Father's Name (First, Middle, Last)			oeth Bek	
Maryland 21215-0036	2 should and Mer is marke eumatic	၉	John Punko 19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street and Number or Rura		
Σ	and 2 sl ealth an n 27 is t		Linda Goff		B Park Street,		
ē,	s 1 ar f Hea ltern other		20a. Method of Disposition	20b. Place of Dispo cemetery, cre			. Location - City or Town, State
Ë	Pages nent of ant: if its ary or o		1 Burial 2 □ Cremation 3 □ Removal fr Character 1 □ Donation 5 □ Other (Specify)	om State	Lta Cemetery 3/2	0/2008 _T	erra Alta, WV
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "neturel; or Iteme 23a or 28a-1 show appringury or other treumatic event, the Marked Examiner count be notified at ance.		21. Signature of Funeral Service Licensee	• 22	2. Name and Address of Facility Arthur H. Wright	t Funera	1 Home
ш	20599		Katherine She	uhic 11	105 Highland Ave	e. Terr	a Alta, WV 26764
			23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause Immediate Cause (Final	on each line.	(a) (i) a Cardiac Cardia Cardiac Cardiac Cardiac Cardiac Cardiac Cardiac Cardi	16 - 1-0	Approximate Interval Between Onset and Death
į.	Physician /Medical		disease or condition resulting in death)	ort Term	effects of sep	tic snoo	IR JURES
	Examiner		(1	rivary tract	infortion-a	tram New	gative ray 3 weeks
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	to (or as a consequence of):	J		
	ocuted nd transi	Examiner	Cause (Diseese or injury that initiated events c				
760,	te be executed ysician and e burial-transit		Due	e to (or as a consequence of):			× 1
687		dical	d				
×	certif nding use as	n/Me		, outcome of pregnancy	Te		23d. Date of delivery
m.	death e atter	iciai	in the past 12 months?	regnant at time of death 5	□Ectopic pregnancy □ Other (specify)		Month Day Year
P.O. Box	at the by the	Physician/Med	9 Unknown	Inknown		CO. Distable	and the second of death?
	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Completed by F	Part II. Other significant conditions contributing Childhood tuber	to death but not resulting in the c	inderlying cause given in Part I.	1 ☐ Yes	co use contribute to the cause of death? 2 No 3 Probably 4 Unknown
Vital Records,	s beer s beer s shou	olete	second degree hea	it block slp	pacerplaceures	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
æ	eician: The law certificate has t lirector, page 2 s	,om	0	. (11/0	performed	death? No 1 ☐ Yes 2 ☐ No
/ita	cian: ertifica	Be C	25. Was case referred to medical examiner?			h (Check only one)	
	Physician: r this certific ral director,	7		1 ☐ Inpatient 2 ☐ ER/Outpatie		me 5 Residence	e 6 Other (Specify) injury occurred
O	ding h. After funer	tion	1 Avatural 5 Pending 2 Accident investigation	Date of Injury Month, Day Year) 28b. Time of Injury	of 28c. Injury at Work? M 1 Yes 2 No		
Division of	or Attending tter death. Director: After in by the fune	Certification:	3 Suicide 6 Could not be 28e. F	Place of Injury - At home, farm, st uilding, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	ot and Number or Rural Route Number, State)
ш	To the Hospital or Attending Physician: The twithin 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	edical Ce	29a. Certifier (Check only (C	o the best of my knowledge, dea he basis of examination and/or in	th occurred at the time, date and place, evestigation, in my opinion, death occur	and due to the caus	se(s) and manner as stated. and place, and due to the cause(s)
	To the H within 24 To the F complete	Medi	one) and	manner stated.	29c License number		. Date signed (Month, Day, Year)
	5 × 8		Millean & athe	10	DZ16650		3-18-2008
7			30. Name and address of person who completed	cause of death (Item 23a) (Type	, Print)		bland, Md 21550
			margaret a Kaise	cmd 1307	9 garrett highu	ay oa	Wand, Md 21550
	Sta		31. Date filed (Month, Day Year) 2 0 20	Registrat's Signature	Hornes &	l	
	Regist	rar	10 9	Brown Control of the	and the second		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AVEND 11FW/18, per INF. 08/8, 4/30/08 WS
State of Maryland / Department of Health and Mental Hygiene

	g - 1	For State Registrar 1. Decedent's Name (First, Middle, I	Last)	Ce	ertificate of E		2. Date of Dea		3. Time of Death
Physicia /Medic	an		Maria Gome	es			Month March		Year 2008 1:04 p
Examin		4a. Facility Name (If not institution, g	give street and number)		4b. City, Town, or	Location of Death		4c. County o	of Death
و منه صبحت	4	Holy Cross Hos	•	d		Iver Spring If Under 24 Hrs.	8. Date of Birt		ontgomery 9. Birthplace (State or Forei
Funeral Director		128-78-8949	. Sex 7. Ag	e (In yrs. last birthda 77 Yrs.	Months Days	Hours Min.	(Month, Da)	y, Year) 30, 1930	Country) Bangladesh
W #		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limit
f sho	ō	Maryland Mont	gomery		Silve:	r Spring			1 □Yes 2 X N
r 28a notii	Director	10e. Street and Number		ı	10f. Zip Code			10g. Citizen of W	hat Country?
23a o st be		802 Downs D	rive			20904		Baı	ng1adesh
Department of Health and Mental Hygiene. Important: to ritems 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	If Yes, Give		B. Was Decedent of Hill If Yes, specify Cubar	spanic Origin? (Spec n, Mexican, Puerto F Specify:	cify Yes or No Rican, etc.)	14. Race Black Specify:	- American Indian, , White, etc.
tural", al Exe	d b	3 Widowed 4 □ Divorced 15. Decedent's	Year or Dates:	16a Dec	edent's Usual Occupa	ation		16b. Kind of Bus	Asian siness/Industry
"nat ledica	Completed	(Specify only highest	grade completed)	(Giv	ve kind of work done d . DO NOT use retired,	luring most of workin	g	700.11110.01.000	,
iene. thar	E	Elementary/Secondary (0-12)	College (1-4or 5	5+)	Homemak	er		O	wn Home
Hyg other ent, 1	BeC	17. Father's Name (First, Middle, La	ıst)			18. Mother's Name	(First, Middle,	, Maiden Surname	9)
fenta rked tic ev	10 B	Dominic	Rozario			-	Agnes Geeclia	Rozario Comes	
s mai		19a. Informant's Name/Relationship	(Type. Print)	19b. Ma	iling Address (Street a	and Number or Rura	Route Numb	er, City or Town, S	State, Zip Code)
alth 27 i er tra		Anthony Gomes	- Son		Deerhead Cou				
nent of He ant: If iten ury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		cemetery, c	position (Name of rematory or other place leaven Cemete	e)	/2008		City or Town, State
Departi Importa any inj once,		21. Signature of Funeral Service Lie	cense	H	22. Name and Addres ines-Rinaldi 1800 New Ham	Funeral Hor		er Spring,	Maryland 20904
		23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caused nly one cause on each li	the death. Do not e	enter the mode of dying	g, such as cardiac o	r respiratory a	rrest,	Approximate Interval Between Onset and Death
nysician		Immediate Cause (Final disease or condition	a. Pneumo	nia					Onset and Bodan
Medical		resulting in death)	Due to (or as	a consequence of):					
xaminer		Sequentially list conditions,	D	e to Thrive					
sit	ine	Sequentially list conditions, if any, leading to immediate		a consequence of):					
and I-tran	Examine	Cause (Disease or injury that initiated events resulting in death) Last	c. Dement Due to (or as	ia a consequence of):					
physician and s the burial-transit	ᇤ		222.12 (27.11.						
ig physician and as the burial-transil	edical		d						
attendir or use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊠ No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Fetal death	3□Ectopic pregnancy 5□ Other (specify)			23d. Date Mor	e of delivery nth D <i>a</i> y Year
ed by the a detached t		Part II. Other significant condition	s contributing to death b	out not resulting in the	underlying cause give	en in Part !.	23e. Did 1	tobacco use contr	ibute to the cause of death?
sigr d be	d b	, and an experience of the control o			, ,		1 🗆	Yes 2 No	3 Probably 4 X Unkno
been	Completed						24a. Was	an 24h. V	Vere autopsy findings availa
has e 2	m						auto perfe	ppsy pormed? d	ndor to completion of cause leath?
(0 1		25. Was case referred to medical				26. Place of Death			☐Yes 2☐No
8 5	o Be	examiner? 1 Yes 2 No	Hospital:	ent 2 ☐ ER/Outpat	ient 3 DOA Othe	or:		idence 6 □Othe	er (Specify)
		27. Manner of Death	28a. Date of Inju	ury 28b. Time	of 28c. Injur			how injury occurre	
h. After funer	tio	1 x Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Da	ay Year) Injur		K? Yes 2 ☐ No			
	Certification:	3 Suicide 6 Could no 4 Homicide determin	ad Zoe, Flace of III	ury - At home, farm, c. (Specify)	street, factory, office	2		(Street and Number wn, State)	er or Rural Route Number,
after death I Director: Id in by the	ē	T-	Physician: To the hest	of my knowledge, de	eath occurred at the tir	me, date and place, a	and due to the ed at the time	cause(s) and ma , date and place,	unner as stated.
n 24 hours after death. In Funeral Director; After Aletely filled in by the fune		29a. Certifier 1 🗷 Certifying (Check only one) 2 Medical E	xaminer: On the basis of and manner st						
within 24 hours after deat To the Funeral Director completely filled in by the	Medical Cerl	(Check only 2 Medical E	xaminer: On the basis of		29c. Licens			29d. Date signed	d (Month, Day, Year)
within 24 hours after deat To the Funeral Director completely filled in by the		(Check only 2 Medical E	xaminer: On the basis of		29c. Licens				
within 24 hours after deat To the Funeral Director completely filled in by the		(Check only 2 Medical E	xaminer: On the basis of and manner st	rated.	29c. Licenso	e number			d (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

					Star	e oi ivia	iryianu / i	Certific		Death	,	eg. Né	08	10266
1	Physic	ian	1. Decedent's Nem								2. Date of Dee Month	Dey	Yeer	3. Time of Deeth
	/Medi		Betty Je 4a. Fecility Name (nd number)				4b. City, Town, or		17, 20		10:45 AM
4	Exami	ner	Egle Nurs						E	Lonaconii			egany	
	Funeral	П	5. Social Security N		6. Sex		(In yrs. last bii		Inder 1 Year	If Under 24 Hrs.	8 Date of Birth		9 Rirthola	e (State or Foreign
	Director		197-20-6		1 □ M 20	₫ F	81	Yrs.	nths Days	Hours Min.	Aug. 14	, 1926	Penns	ylvania
	and		Usual Residence of 10a. State	Decedent 10b. Count	v		10c. City, Tow	n or Location	1				100	I. Inside City Limits
	Maryli f sho	5	MD	Garre			•	ndsvill					100	1 ☐ Yes 2 ☑ No
	284 1	Tec.	10e. Street and Nui				rere		f. Zip Code		1	0g. Citizen of	What Country	/?
	ath with the Marylan 23a or 28a-f show wat be notified at	Funeral Director	3277 Frie	endsvi	11e-Addi	son R	đ.		21531			USA		
	deat	ner	11. Marital Status		12. Was	Decedent Eved Forces?				Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No-	14. Rac	e - American	
21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f show any Injury or other traumatic event, the M. dical Examiner must be notitied at once.	by Fu	1 ☐ Never Marri 3 ☑ Widowed	_	rried 1 🗆	Yes 2 ☑ No is, Give r or Dates:	•		es 21/2 No		o Aican, eic.)	Specif	ck, White, etc v: Whi	
5-0	72 ho	Completed by	(Spec		nt's Education est grade comple	atod)	16a.	Decedent's	Usual Occup	pation	ting	16b. Kind of B	-	
21	ithin.	nple	Elementary/Seco			ege (1-4or 5+	.)	life. DO NO	OT use retire	during most of world)	Kirig			
	led w lygier ner th	S	12	· · · · · · · · · · · · · · · · · · ·			Ho	memake	er	T		Own H		
Maryland	ntal H	Be	17. Father's Name								ne (First, Middle, I	Maiden Suman	ne)	
Ĩ	hould d Me mark matic	2	John R. (19a. Informant's Na			1	10b	Mailing Ada	drana (Strant	Mabel E	. Weigle	City or Town	State 7in C	ode) 21531
S	than than tris	1 3	Dorsey R			,		-		ille-Add:				
re,	s 1 ar f Hea item 2		20a. Method of Disp		-,		20b. Place of cemeter					20c. Location		
Ē	Page ent o nt: if i		1 🔀 Burial 2 [4 🗆 Donation		3 □Removal Specify)	from State	Mercy (rch 21,	2008 Fr	riends	ville, MD
Baltimore,	permit. Departm Importal any Inju		21. Signature of Fu			1	-			ess of Facility Ne				
m	99		1.00	hu,	leun	(a.)				75, Grani			531	
)	Physician /Medical Examiner	ler	23a. Part1. Enter the shock, or heal immediate Cause (disease or condition resulting in death)	Final	(ARCI.	ve m f	Lin	NG					pproximate Iterval Between Inset and Death
	tificate be executed g physician and as the bunal-transit	Examiner	Sequentially list cor if any, leeding to im	nditions, mediate	f b	Di	ue to (or as a o	consequence	of):					
68760,	the buni	Medical E	Sequentially list cor if any, leeding to im cause. Enter Unde Cause (Disease or that imitated events resulting in death) L	rlying injury (.a.st	C	Di	ue to (or as a c	onsequence	ot):	-			1	
	- C/ W	/Me			d									
. Box	death cert a attendin d for use	icia	Part II. Other signifi	cent conditi	one contributing	to death but	not resulting in	the underlyi	na cause ab	on in Part I	23h Did to	hecco use co	ntribute to th	ne cause of deeth?
P.O.	that the de led by the detached	/ Physician/			C GAS							es 2 🗆 No		
Division of Vital Records,	The law requires that the death cer ate has been signed by the attendin page 2 should be detached for use	Completed by									24a. Was a perforr	n autopsy ned?	availa	autopsy findings able prior to eletion of cause eth?
Ĕ	The lav ate has page 2	E									1 □ Ye	s 2 No		res 2□ No
ita		Be	25. Was case referr	ed to medica	ıl					26. Place of Dea	th (Check only on	e) /-		
<u>></u>	S 50	2	examiner?			1 🗆 Inpatient		tpatient 3	DOA Oth	ner: 4 Nursing H	ome 5 Reside	ence 6 □Oth	er (Specify)	
ono	Attending Ph ir death. ector: After th by the funeral	ation:	27. Manner of Death 1 Natural 2 Accident	5 Pendi	ng (Date of Injury Month, Day Y	/ear) 28b. T	ime of njury M	28c. Injur Wor 1 🔲	yat k? Yes 2 ∐ No	28d. Describe ho	w injury occur	red	
DIVIS	P # # =	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could determ	nined 206. F	Place of Injury uilding, etc.	y - At home, fai (Specify)	rm, street, fac	ctory, office		28f. Location (St City or Town		er or Rural F	Route Number,
	To the Hospital within 24 hours a To the Funeral C completely filled	edical	29a. Certifier (Check only one)	1 Certifyii 2 Medical	Exeminer: On the	the best of r ne basis of ex manner state	xamination and	death occur d/or investiga	red at the tin tion, in my o	ne, date and place pinion, death occur	and due to the carred at the time, da	ause(s) and ma ate and place,	anner as state and due to th	ed. ne cause(s)
	To the Comp	×	29b. Signature and t	itle of certifie	er				29c. Licens	e number	2	9d. Date signe	d (Month, Da	ly, Year)
				9	July				00	76907		m arch	19:	2008
		2	30. Name and addre									01555		
	Sta Registr	re	Dr. Harji 31. Date filed (Month	n, Day, Year,	2 0 200	2. Registrar's	s Signature		1 Rd.	Cumperla	and, MD	21502		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 1 18

			1 - For State Registrar		State o	f Maryla	and / De <i>C</i>	partme <i>ertifica</i>	nt of F te of	lealth <i>Death</i>	and M	ental Hyg	jiene 🤈	008	1026	7
	Physici	an	Decedent's Name (Fin			.a1.d						2. Date of Dea Month	Day	Year	3. Time of Death 7:15 pM	
	/Medio Examin		4a. Facility Name (If not		Hirshf street and nu			4b. City	y, Town, o	r Location	of Death	March	12 4c. Coun	ty of Death	7.13 pW	
				rban Hosp						hesda				Montgo	nery	
i A	Funeral Director		5. Social Security Number 094-32-5687		ex □M 2 ⊠ F	7. Age (In y	rs. last birthda Yrs	Months	er 1 Year s Days	If Unde Hours	Min.	8. Date of Birth (Month, Day October	, Year)	9. Birthp	lace (State or Foreign try) Israel	7
	land w t		Usual Residence of Dec 10a. State 10b	edent . County		10c.	City, Town or	Location						1	0d. Inside City Limits	
	h the Marylan r 28a-f show s notified at	tor	Maryland	Monte	omery				Che	vy Cha	ase				1 X Yes 2 □ No	
	with the	Director	10e. Street and Number		, , , ,			10f. Z	ip Code			1	0g. Citizen of	What Cour	itry?	
	feath wi		4601	North Pa						208				U.S.A		
36	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show ledical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 3 □ Widowed 4 □		12. Was Dec Armed Fo 1 ☐ Yes If Yes, Gi Year or D	orces? 2 🔀 No ve	U.S. 1	 Was Dec If Yes, sp 1 ☐ Yes 		lispanic O an, Mexica Specify		cify Yes or No- Rican, etc.)		ace - Americack, White,		
9	2 hour atural cal Ex		15.	Decedent's Ed	ucation		16a. De	cedent's Us	ual Occup	ation			16b. Kind of I			_
21215-0036	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medicalone.	Completed	(Specify of	nly highest grad y (0-12)	College (1-4or 5+)	(Gi life	ve kind of we DO NOT	ork done o use retired iologi		st of workir	ng	Unite	d Mina	Worker	
P	al Hyg other vent, t	Be C	17. Father's Name (First	, Middle, Last)					lologi		ner's Name	(First, Middle,			WOLKEL	
ylar	Duld by Ments arked atic e	To E	Manoah	Bialik							(Clara Tel	ushkin			
Mar	12 sho		19a. Informant's Name/i		,		- 1					l Route Numbe	-		,	
<u>6</u>	1 and Healt tem 2		Alan Hirsh 20a. Method of Disposition		usband	206	. Place of Dis	position (Na	ame of	i		302, Chev	y Chase, 20c. Location		and 20815 wn. State	
Baltimore, Maryland	tment of tant: If it iury or o	74	1 🗷 Burial 2 □ Cre 4 □ Donation 5 □	emation 3 🗌 Other (<i>Specify</i>)		cemetery, c udean Me	morial	Garde	ns	03/14/	2008		ey, Mar		
Bal	permit Depar Impor any in	h	21. Signature of Furrera	Service Licens	see *				Rinald	i Fune	eral Ho	ome, Inc. nue, Silv	er Sprin	ıg, Mar	yland 20904	
- n	Physician		23a. Part1. Enter the dis shock, or heart fail Immediate Cause (Final disease or condition	ure. List only o	one cause on e	aused the de each line.		enter the mo	ode of dyin	ng, such a	s cardiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death	
5	/Medical Examiner		resulting in death)		Due to	or as a cons	equence of):		•							_
5 P		-	Sequentially list condition	ns,	D	ney Fai: oras a cons								_	·	_
5 B	outed ansit	Examiner	Sequentially list condition if any, leading to immediately Cause (Disease or injury that initiated events	1	c	`								-53		
% %	be executed ician and burial-transit	Ex	that initiated events resulting in death) Last		Due to	or as a cons	equence of):								4,1,4	
80/	icate t physic s the b	edical			d											_
3/12 Box	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent preg in the past 12 mont 1 ☐ Yes 2 ☒No	giiaiii	4□Pregr	oirth 2 □ Fe nant at time o	etal death	3 □Ectopic 5 □ Other (s		,			I .	ate of delive	ery Day Year	
O. 9	at the I by the	hys	9 ☐ Unknown		9□Unkne											
md,	requires the	þ	Part II. Other significant	conditions co	ontributing to de	eath but not re	esulting in the	underlying	cause give	en in Part	I. 				ne cause of death? ably 4 ⊠ Unknown	ı
Sarlnd Ital Records	e law re has be e 2 sho	Completed										24a. Was a	sv l	prior to cor	psy findings available npletion of cause of	÷
	n: Th ficate r, pag		05.14									perfor 1□ Yes		death? 1 ☐ Yes	2□No	_
	Physician: r this certific ral director,	To Be	25. Was case referred to examiner? 1 ☐ Yes 2 ☒ No	-	Hospital:	nnatient 2	☐ ER/Outpat	ent 3□ D	Othe	or:		(Check only on ne 5 ☐ Reside				
Fellonor	fing Afte fune		27. Manner of Death	Pending investigation	28a. Date	· · · · · · · · · · · · · · · · · · ·	28b. Time	of	28c. Injun Work		2	8d. Describe h			/)	_
, i	after death after death Director;	Certification:		Could not be determined	28e. Place buildi	of injury - At ng, etc. (Spe	home, farm, socify)					8f. Location (Since City or Town	treet and Num n, State)	nber or Rura	l Route Number,	
Ī		Medical C	29a. Certifier 1 🛣 (Check only one)	Certifying Phy Medical Exam	iner: On the ba	best of my k asis of exami ner stated.	nowledg e , de ination and/or	ath occurre	d at the tin	ne, date a pinion, de	and place, a	and due to the co	ause(s) and n late and place	nanner as s e, and due to	ated. the cause(s)	47
	To the To the Complex complex	Me	29b. Signature and title of	of certifier	7			29	9c. License	e number		2	9d. Date sign	ed (Month,	Day, Year)	
	12			1	2 5.	willes			D631	95			March	13, 200	08	
			30. Name and address o		ompleted caus	e of death (Ite										
	C.W.		Steven D. 31. Date filed (Month, Da			0 01d Ge egistrar's Sig		n Road	, Beth	esda,	Maryla	and 20814				_
15	Stat Registra	-	MAR	17 200			y. So	act o								

08-02253 Roy Felix Hill Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

oy F	elix Hill		State of Maryland / Department	artment of rtificate of	Health Death	n and	Mental H	R	eg. No. 20	08 1026
Y	Physicia Exami	ın/	I. Decedent's Name (First, Middle,Last) Roy Felix Hill					2. Date of Dea Month March 21	Day Year , 2008	3. Time of Death 1615 hrs
2			4a. Facility Name (if not institution, give street and number) 25 Bronco Court	4	b. City, To Germa		ocation of Dea		4c. County of De Montgomery	/
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. 214-96-7761 1x M 2 F 32		If Under Months		If Under 24H Hours M	in.		Birthplace (State or eign Country) Maryland
	w any		Usual Residence of Decedent	y, Town or Location	on					10d. Inside City Limits 1 Yes 2 X No
1	vlaryland 28a-f show any d at once.	Director	Maryland Montgomery 10e. Street and Number		10f. Zip	erman Code	town		109. Citizen of What C	ountry?
3	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho al Examiner must be notified at once.		25 Bronco Court 11. Marital Status 1 Never Married 2 Married Armed Forces?	U.S. 13. Wa	s Deceder es, specify	208 nt of Hispa Cuban, I	anic Origin? (Specify Yes or N rto Rican, etc.)	U.S.A o- 14. Race - An White, etc	nerican Indian, Black,
6		2	Wildowed 4 Divorced in res, sive real or Dates: Or Dates: 16b. Decedent's Usual Occupation (Give kind of work done 16b.)							White ss/Industry
9	5-00.50 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12	during me	ost of work	king life. [espers	OO NOT use i	retired)	Reta	ail
1		Be Con	17. Father's Name (First, Middle, Last) Roy Franklin Hill]	Dorothy An		
	MID Z1Z1 d 2 should be f lth and Mental n 27 is markee aumatic event,	10	19a. Informant's Name/Relationship (Type, Print) Meredith T. Hill - Spouse						umber, City or Town, S 1and 20874	
	TOFE, MID ages I and 2 shount of Health and Note I fitem 27 is nother transmatic		1 Burial 2 X Cremation 3 Removal from State	o. Place of Dispos crematory or oth ort Lincol	her place)			Date 3/30/2008	20c. Location - City Brentwood	
b :	Baltimore, I permit. Pages I and Department of Heal Important: If item injury or other tra		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	111	800 Ne	w Ham	pshire .	1 Home, In Avenue, Si	lver Spring,	Maryland 20904
1	ີ່ hysician ໄລໄເລໄ	8 1	23a. Part I. Enter the disease, or complications that caused the dea failure. Let only one cause on each line. Immediate Cause (Final disease a. Narcotic (Mor. hi				such as cardia	ac or respiratory a	rrest, shock, or heart	Approximate Interval Between Onset and Death
	∟xaminer		or condition resulting in death) Due to (or as a consequence b.							
		Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence consequence)							
	50, te be executed systeian and burial - transit	edical E	d. X UNPENDED AMENDED 23a,27,2	'8a-f per l	ME g87	8 4/4	/08 amh			
	, P.O. Box 68760 ires that the death certificate be signed by the attending physical be detached for use as the but	Š	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	2 F	etal death	3 [Ectopic pre	egnancy	23d. Date of de Month	livery Day Year
	.O. Bc hat the dea ed by the a letached fo	by Phys	Part II. Other significant conditions contributing to death but no	ot resulting in the	underlying	g cause g	iven in Part I.			te to the cause of death? Probably 4 Unknown
	Division of Vital Records, P.O. Box 68766 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physomptetely filled in by the funeral director, page 2 should be detached for use as the b	Completed t						ре	topsy prio rformed? dea	re autopsy findings available or to completion of cause of th? Yes 2 No
	tal Recian: The certifical ector, pa	Be C	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2	ER/Outpatier	y 3 1		of Death (Ch	eck only one) ursing Home 5	Residence 6 🗸	Other: Scene
	n of Vi ding Physi h. After this	on: To	1 ✓ Yes 2 No Impatient 2 27. Manner of Death 1 Natural - (Month, Day, Year)	28b. Time of	Injury	28c. Inju	ry at Work? Yes 2 X No	28d. Descri	be how injury occurred	
	Division of Vital Records, To the Hospital or Attending Physician: The law requir within 24 hours after death. complete Iteraral Direct. After this certificate has been a completely filled in by the funeral director, page 2 should	Certification:	2 Accident 3 Suicide 4 Homicide See Pending Investigation Find 3/21/08 Could not be determined Specify)Residence Specify)Residence Accident Specify Spe			y, office b	uilding, etc.	28f. Locatio or Town	n (Street and Number n, State) 25 Brond	or Rural Route Number, City to Ct.Germantown,
	the Hospi thin 24 hou the Funer mpletely fil	Medical Co	29a. Certifier 1 Certifying Physician: To the best of my know one) 2 Medical Examiner: On the basis of examination and manner stated.	ledge, death occi in and/or investig	urred at th ation, in m	e time, da ny opinion	ate and place , death occur	, and due to the c red at the time, d	ause(s) and manner a ate and place, and due	s stated. e to the cause(s)
	F. 18 8	Me	29b. Signature and title of certifier	0	29	O.C.	e number	OCME	March 22, 20	(Month, Day, Year)
	(D)		30. Name and address of person who completed dauge of death/(I Theodore M. King, Jr., MD. Assistant Medica		111 P	enn St	reet, Baltir	nore, MD 212	201	
	Pagi	tate	31. Date filed (MAR) ay 2 ea 2008 32. Registrar's Sign	nature	ast 1	•				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death Day **Physician** HAVEN M 2008 March 11, 1445 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fort Washington Hospital Fort Washington Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Days Hours 1 □ M 2 🖸 F Yrs. Director 060-14-1571 87 10-15-1920 New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location f show 10d. Inside City Limits a or 28a-f show be notified at MD Prince George's Oxon Hill Director 1XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death wi Department of Health and Mental Hyglene. Important: If flean Z7 Is marked other than "natural", or items 23a i any injury or other traumatic event, the Medical Examiner must b. 2136 Alice Avenue 20745 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc 1 Yes 2 No If Yes, Give Year or Dates: 1 XNever Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Housekeeping A. Holly Patterson 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Unknown ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2136 Alice Avenue Oxon Hill, MD Betty L. Smith/The Agent 20745 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 03-18-2008 | Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall's Funeral Home of MD D. CRAY 4308 Suitland Road Suitland, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MINAU UNKNOWAL /Medical **Examiner** LM KNO WWO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed burial-transit and Box 68760, attending physician Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death ed by the a detached f 5 ☐ Other (specify) P.0. 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ð 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has be 2 s autopsy page perforn certificate 1□ Yes or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient After this funeral dir 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Manner of Death 28a. Date of Injury Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident (Month, Day 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year)

State

State 31. Date filed (Month, Day, Year)

Registrar MAR 1 8 2008

Samuel J. Kleiman

11711 Livingston Road Fort Washington, MD
32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

20744

Certificate of Death

4b. City, Town, or Location of Death

2. Date of Death

March

Month

Day

Year

Prince George's

14. Race - American Indian,

H. G. Smitty, Inc.

Black, White, etc.

2008

4c. County of Death

USA

Specify:

16b. Kind of Business/Industry

20c. Location - City or Town, State

9.20 PM

Birthplace (State or Foreign Country)

South Carolina

Black.

10d. Inside City Limits

Approximate Interval Between Onset and Death

15 min

1 1XTYes 2 □ No

Prince George's Community Hospital Cheverly 8. Date of Birth (Month, Day, Year) 4/14/1918 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ★M 2 F 89 Director 579-14-0664 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County show r 28a-f show notified at **Bladensburg** Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 3801 Kenilworth Avenue Apt. 114W 20710 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No þ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) the Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown ပ Eula Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Kevin E. Holbrook/Son 3801 Kenilworth Ave., Apt 114W, Bladensburg, MD 2071 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition it. Pages 1 artment of F ortant: If ite 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 3/18/2008 Brentwood, Maryland 5 Other (Specify) 4 □ Donation 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, MD 23a. Part1. Envir the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ARRYTHMIA , ASYSTORE /Medical Due to (or as a consequence of): Examiner ARTERIOSCLEROTIC HEART sequentially has concard a if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be execute PACEMAKER FOR burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical HYPERIENSION IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERLIPIDEMIA, CARCINOMA PROSTATE Completed CHRONIC OBSTRUCTIVE PULMENARY

1	23e. Did tobacco use	contribute to the cause of death?
	1 Yes 2 2 ⊀ N	No 3 ☐ Probably 4 ☐ Unknown
	24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
(C	Check only one)	
е	e 5 ☐ Residence 6 ☐	Other (Specify)
30	d. Describe how injury of	courred

23d Date of delivery

Day

Year

Month

1 ☐ Yes 2 🔀	No	Hospital: 1 ☐ Inpatient 2 ∑	ER/Outpatient 3□		OA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Deatl 1 XNatural 2 ☐ Accident	5 Pending investigation		28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of injury - At h building, etc. (Spec	nome, farm, stree	t, factor	y, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one)						ce, and due to the cause(s) and manner as stated. curred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier Lhis hawill

MAR 1 8 2008

25. Was case referred to medical examiner?

1. Decedent's Name (First, Middle, Last)

Earl Duke Holbrook

4a. Facility Name (If not institution, give street and number)

Physician

/Medical

Examiner

29c. License number D0033503 29d. Date signed (Month, Day, Year) 3.13.08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

DR. LEELA KRISHNAMURTHY, 9470 Annapolis Rd 301, Lamham MD 20706 31. Date filed (Month, Day, Year)

State Registrar

completely

the within To the Be

Certification: To

Cal

32. Registrar's Sign

State of Maryland / Department of Health and Mental Hygiene State Registramend#18.PerFHPGC3-19-08cm Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Chevelle T. Hall 03 112008 0924 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X**□M 2□F 579 82 1489 44 Director 10/12/1963 D.C. Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County ms 23a or 28a-f show 10d. Inside City Limits MDMontgomery Director Gaithersburg 1 ▼Yes 2 No 10e Street and Number 241 Lower Country Drive 10f. Zip Code 10g. Citizen of What Country? 20877 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. , 01 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK 3 "natural", 3 ☐ Widowed 4 ☐ Divorced Completed r than "natur the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Engineer Hughes Network System 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) Be Randolph Hall Clynnora Hall McDonald 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5207 12th St. NE Washington, DC 20011 Kevin A. Hall BROTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If iter
any injury or oth 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 03/17/2008 Landover, Maryland 4 Donation 5 Other (Specify) Harmony Memorial 22. Name and Address of Facility John T. Rhines Funeral Home, LLC 21. Signature of Funeral Service Licensee 3005 12th St. NE Washington, DC 20017 23a. Pf.ft1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Cardiac Arrhythmia minutes /Medical Due to (or as a consequence of) Examiner Diabetes Mellitus Sequentially list conditions, years Examiner cause. Enter Underlying Cause (Disease or injury that initiated events law requires that the death certificate be executed and use as the burial-trai resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Renal Transplant 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Obesity 24a. Was an autopsy 1∐ Yes 2**X** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 X Natural Injury 1 ☐ Yes 2 ☐ No spital or Attendious after death. 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature 29d. Date signed (Month, Day, Year) 30. Name an address of person Nicole Veteri oleted cause of death (Item 23a) (Type, Print) Rockville, Maryland 20850 9901 31. Date filed (Month, Day, Year) MAR 1 8 2008 Registrar

DHMH 17 Rev 1/2001

			For State Registrar	State of Ma		epartment of Certificate of		Mental Hy	/giene Reg. No		10272
	Dhysisi	- 10	1. Decedent's Name (First, Middle, La					2. Date of Do Month	eath Da	ıy Year	3. Time of Death
	Physicia /Medic		Donald Bru		S			March		8, 2008	0730 A M
	Examin	er	4a. Facility Name (If not institution, giv	•		, ,	or Location of Dea	th	40	County of Death	
	<u> </u>		201 Bloomingd 5. Social Security Number 6. 8	ale Avenu	1 e e (In yrs. last birtho		erals burg	8. Date of Bi	irth	Carolin	nace (State or Foreign
. €	Funeral Director			XDXM 2□F	89 Yrs	Months Day			ay, Year,) Cou	York
	land ow tt		10a. State 10b. County		10c. City, Town o	r Location					10d. Inside City Limits
	Mary -f sho	ţo	MD Carol:	ine		Federa	alsburg				1xXes 2□No
	r 28a	Director	10e. Street and Number			10f. Zip Code			10g. Ci	tizen of What Cou	ntry?
	th wit	a D	201 Bloomingda	ale Avenu	ı e		21632		Un	ited St	ates
	r dea	Funeral	11. Marital Status	12. Was Decedent I	Ever in U.S.	 Was Decedent of If Yes, specity Co 	Hispanic Origin? (Jban, Mexican, Pue	Specify Yes or N rto Rican, etc.)	0-	14. Race - Ameri Black, White,	
220	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ I If Yes, Give Year or Dates:	42–45	1 ☐ Yes 2 💢 N	o Specify:			Specify: W	nite
ָ כ	72 hc 'natu dical	Completed	15. Decedent's E (Specify only highest gra	ducation ade co <i>mpleted)</i>	16a. D	ecedent's Usual Occ Give kind of work don fe. DO NOT use reti	upation e during most of wo	orking	16b. k	Cind of Business/Ir	ndustry
7	vithin me. han '	mp	Elementary/Secondary (0-12)	College (1-4or 5	T)	neral Di			Mo	rticiar	ı
7	ould be filed with Mental Hygiene. arked other thar atic event, the M	ပ္ပ	17. Father's Name (First, Middle, Last)	1 - 4.			ame (First, Middle	e, Maidei	n Surname)	
2	d be antal	o Be	William D. Ha				Pear1	Schoor	nmak	er	
	2 should be and Mental is marked or aumatic ever	70	19a. Informant's Name/Relationship (19b. M	Mailing Address (Stre					p Code)
M	and 2 sealth all n 27 is		Margaret S. Ha	wkins/Sp	ouse 20	1 Bloomi	ngdale .	Ave., I	ede	ralsbur	g, MD
ָ ט	sta of Hea Item		20a. Method of Disposition		20b. Place of D cemetery,	isposition (Name of crematory or other p	lace)	Date	20c. L	ocation - City or T	own, State
	Pages ment of I ant: If Ite ury or of		1 ☑ Bunal 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (<i>Speci</i>			est Cemete	ery 03			eralsbu	
Dall	permit. Pages 'Department of H Important: If Ite any Injury or of		21. Signature of Funeral Service Lice	Edrow	_	22. Name and Add	dress of Facility Finance	rampton Federals	n Fu sburg	neral H g, MD 216	Home, P.A 532
ľ			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. Do not	t enter the mode of d	ying, such as cardi	ac or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			ilar Acci					Onset and Death
	/Medical		resulting in death)		a consequence of)						
	Examiner	_	Sequentially list conditions,	b. Atri		llation					2 years
-	be sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	\	a consequence of)	c Cardio	vaccula -	Diene	E 10		1.000
	xecut and II-tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		a consequence of)		vascular	171566	PC		years
6,00	icate be executed physician and s the burial-transit	edical E		а. Нуре	ertension,	Hyperlip	iclemia				years
~		Med	IF FEMALE:	00-15	of exceptions.						
9	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 ☐ Ectopic pregnar 5 ☐ Other (specify)				23d. Date of delive Month	Day Year
	that the ed by detac		Part II. Other significant conditions	contributing to death b	ut not resulting in th	he underlying cause	given in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
, DIC	puires n sign lld be	d by	Pulmonary Hype	rtension,	Congoshi	le Heart i	Failure,	1 🗆] Yes 2	2□No 3□Pro	obably 4 Mnknown
5	aw rec s beer 2 shou	Completed	Hypertension		•			24a. Wa	s an opsy	24b. Were aut	topsy findings available ompletion of cause of
	The late ha	mo	The state of the s					per 1⊡ Yes	formed?	death?	2 5 No
2	ilan: ortifica ctor, p	Be C	25. Was case referred to medical examiner?				26. Place of D	eath (Check only	one)		
>	hysic his ce I direc	ToE	1 ☐ Yes 2 ZNo		ent 2 ER/Outp	allerit SLI DOA	Other: 4 Nursing			6 □Other (Spec	ify)
5	Ing Pl		27. Manner of Death 1 Natural 5 Pending	28a. Date of Inju (Month, Da		ury V	ijury at /ork? □ Yes 2 □ No	28d. Describe	e how inji	ury occurred	
2	death death stor: , the	icat	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	e 28e Place of ini	urv - At home, farm	n, street, factory, office		28f. Location	(Street a	and Number or Ru	ral Route Number,
2	after Direction by	Certification:	4 ☐ Homicide determined	building, et	c. (Specify)	,		City or To	own, Sta	te)	
	Hospita 24 hours Funeral stely filler	Medical C	29a. Certifier 1 Certifying P	hysician: To the best miner: On the basis o and manner st	f examination and/	death occurred at the or investigation, in m	e time, date and pla ny opinion, death oc	ce, and due to the	e cause(e, date a	s) and manner as nd place, and due	stated. to the cause(s)
	o the	Med	29b. Signature and title of certifier			29c. Lice	ense number		29d. D	ate signed (Month	ı, Day, Year)
	->-0		You hadi	a. neal	m.i	1	0054812		n	narch 19,	2008
			30. Name and address of person who			5:0					
			Kimberlie A. Near	1, MiD 3	304 Hay	man Dove	, Federa	Khun, 1	Cim	21632	
	Sta		31. Date filed (Month, Day, Year) MAR 1 9 200	32. Registr	ar's Signature	and a					
	Registi	ar	MALL T A SDA		100						

DHMH 17 Rev 1/2001

KIIIT

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Francis Edward 2008 12:45 A Hart March 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 17540 Henderson Road Marydel Caroline If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 80 yrs 8. Date of Birth (Month, Day, Nov. 4 9. Birthplace (State or Foreign Country) Maryland **Funeral** Days Hours 220-12-5256 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 23a or 28a-f show must be notified at 1 □Yes 2 No Director Maryland Caroline Marydel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17540 Henderson 21649 Road USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No White Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Army Corp of Engineers Tugboat Captain 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Hart Mary Eder Hart ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jane M. Hart/ wife 17540 Henderson Road; Marydel, Maryland 21649 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State Greensboro Cemetery | 03/22/2008 4 ☐ Donation 5 ☐ Other (Specify) Greensboro, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fleegle and Helfenbein Funeral Home, PA PO Box 160; Greensboro, Maryland 21639 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Atrial Fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed orgestive Heart Failure Due to (or as a consequence of): P.O. Box 68760, Churue Obstruction Relumary Diseas Physician/Medical attending for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s autopsy performed? 1 Yes 2 W No or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death.

To the Funeral Director: After completely filled in by the funeral 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the ! 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Bulsan P. Whan W) D0050872 03-18-08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 316 Railroad Ave.; Goldsboro, MD 21636

Registrar DHI/H 17 Rev 1/2001

State

Barbara Urban, MD 31. Date filed (Month, Day, Year)

MAR 1 9 2008

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March 12 2008 ear **Physician** 9:00A Karen Ne11Hayman /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Caroline Greensboro 14370 Cedar Lane 8. Date of Birth (Month, Day, Ye March 26 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday)
54 Yrs. **Funeral** Hours 6 1953 West Virginia Months Days Min. 1 □ M 2 🕅 F Director 219-64-5162 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show ns 23a or 28a-f shov must be notified at 1 ☐ Yes 2 No Director Caroline Greensboro Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21639 USA 14370 Cedar Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, r than "natural", or Items the Medical Examiner mu 11 Marital Status Black, White, etc. 72 hours after 1 □ Never Married 2 Married White 1 ☐ Yes 2 No Saltimore, Maryland 21215-0036 à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) marked other than Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be fill h and Mental H 7 Is marked ott Be Mary Edwards Mitchem Eugene Roy Mitchem 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If Item 27 Is may Injury or other 14370 Cedar Lane; Greensboro, Maryland 21639 Eugene Hayman/husband Chester 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State March 16 2008 4 □ Donation 5 □ Other (Specify) Denton Cemetery Denton, Maryland 22. Name and Address of Facility
Fleegle and Helfenbein Funeral Home, PA
PO Box 160; Greensboro, MD 21639 21. Signatury of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE MYOCARDIAL INFARCTION ACUTE /Medical Due to (or as a consequence of Examiner CARDIOVASCULAR DISCOSE C VERTENSIVE HRONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner the burial-trai law requires that the death certificate be execu Due to (or as a consequence of) physician attending IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month for in the past 12 months? 1 ☐ Yes 2 ■ No 4□Pregnant at time of death 5 Other (specify) g Unknown ģ Part 77. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed I page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by ARTHRI 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2□ No 1 ☐ Yes certificate 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specity)

Box 68760, P.O. Division or Vital Records, Physician: After this Hospital or Attending 24 hours after death. filled in by within 24 hor To the Fune

Certification: To

1 Yes 2 No

29a. Certifier (Check only

27. Manner of Death 5 Pending investigation 1 Natural

2 Accident 6 Could not be 3 ☐ Suicide 4 Homicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28a. Date of Injury (Month, Day Year)

DEPUTY 29c. License number **D14664**

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Pay, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

and address of person who completed cause of death (Item 23a) (Type, Brint)
Is Kien E. Jensen MD, POBHESO, DENTON MD 21629

28b. Time of

State Registrar

Medical

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 10^{ay} 2008 **Physician** 3:45 Horace William Johnson /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Bethesda Surburban Hospital Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday 5. Social Security Number 6. Sex Funeral 579 68 0827 1 ☑ M 2 □ F 56 12/31/1951 D.C. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County show r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at 1√ Yes 2 No Montgomery MD Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20906 United States 3912 Ferrara Drive Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No Specify: BLACK Specify. \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Painter Department of Health and Mental Hygie Important: If item 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ellen Walker James Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 3912 Ferrara Drive Silver Spring, MD 20906 Felecia Bowen NIECE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kivadale, Hanglano 3/20 /2008 Kiverdale Crematoria 22. Name and Address of Facility John T. Rhines Funeral Home, LLC 21. Signature of Funeral Service Licensee 3005 12th St. NE Washington, DC 20017 recen art1. Enter the disease, or complic tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one chase on each line. Approximate Interval Between 1 Week I minediate Cause (Final disease or condition resulting in death) **Physician** aAnoxic Encephalopathy /Medical Due to (or as a consequence of) Examiner 1 week _{b.}Cardial Arrythmia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine vears $_{c}$ Hypertension Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 years Physician/Medical renal Failure nse 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2**X** No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Injury 1X Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State

545

0-2008

1

Ohrson, Horaco

31. Date filed (Month, Day, Year, MAR 1 8 2008

Signature and title of certifier

30. Name and address of person who compl. James Salander 1119

ed cause of death (Item 23a) (Type, Print) Rockville Pike Rockville, Maryland 20852 32. Registrar's Signature

Registrar

29c. License number

D39064

29d. Date signed (Month, Day, Year)

03/11/2008

			State State	of Marylan				Mental Hyg	giene		
			Registrar		Cei	rtificate of I	Jeath	2. Date of Dea	Reg. No.2	10276	
	Physici		1. Decedent's Name (First, Middle, Last) Lester Rudolph Jackso	n				Month March	14, 2008	3. Time of Death 8:25 P. M	
	/Medic	-	4a. Facility Name (If not institution, give street and	number)		4b. City, Town, or	Location of Dea	th	4c. County of Death		
			Prince George's Hospit	al Center		Cher	verly		Prince George's		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		9. Bird	chplace (State or Foreign puntry) (IMDIa, S.C.	
ok.	Director		579-01-9656 Usual Residence of Decedent	75				02/24/1	913 (010	mora, b.c.	
halv	at		10a. State 10b. County		, Town or Lo					10d. Inside City Limits	
Mar	3a-f st tified	ctor	D.C.	W	ashing	rton				1 □Yes 2 No	
with th	a or 28 be no	Director	10e. Street and Number 805 55th St., N.E.			10f. Zip Code	20019		10g. Citizen of What Co		
4	ms 23	Funeral	11 Marital Status 12. Was I	ecedent Ever in U.	S. 13. \	Was Decedent of H f Yes, specify Cuba		Specify Yes or No-		rican Indian,	
o dife	or Ite	Fur	1 Never Married 2 Married 1 Married	Forces? es 2 No Give 44-		f Yes, specify Cuba 1 □ Yes 2 ⊠ No	in, Mexican, Pue Specify:	rto Rican, etc.)		e, etc. Black	
	tural", al Exa	d by	3 Widowed 4 Divorced Year	r Dates: 44-		dent's Usual Occup					
in 2	n "nal	plete	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) Collection		(Give	kind of work done of NOT use retired	during most of wo	orking	16b. Kind of Business	muustry	
Z A	giene er tha the l	Completed	12th	e (1-4or 5+)	С	lerk			Map Servi	.ce	
5, IVIDI YIDIIO Z.I.Z.I.O.OOO	f Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To Be (17. Father's Name (First, Middle, Last) Louis Jackson					me (First, Middle, etta Wil	,		
al y	and M s mar sumat	-	19a. Informant's Name/Relationship (Type. Print)						r, City or Town, State, I	Zip Code)	
and ;	Health em 27 I		Lillian W. Jackson/Wif			55th St., I	W.E.,Was	hington, I			
Pages	nent of int: If It iry or o		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Removal fr 4 □ Donation 5 □ Other (Specify)	٥ ٥	emetery, cirer coln M	natory or other place iem. Cem.	03/	21/08	20c. Location - City or Suitland, M	Maryland	
Dermit Day	Depart Import any inj once,		21. Signature of Funeral Service Licensee	Pratt	- 4	Name and Address 1925 Burro	nington Sughs Av	& Sons Co	o Inc. Washington,	D.C.20019	
г			23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of	at caused the death	n. Do not ente	er the mode of dyin	g, such as cardia	ac or respiratory ari	rest,	Approximate Interval Between	
	nysician		Immediate Cause (Final disease or condition	Acc	ile	myoca ii st	erdia	mfar	dem	Onset and Death.	
	Medical xaminer		resulting in death)		days						
	**	ner	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	to (or as a consequ	ience(of).					class	
ecuter	and -trans	Examiner		to (or as a consequ		hloeod	caso o	bactere	me	Clarge	
or oc,	physician and the burial-transit	dical E		to (or do d consequ	201100 01).						
ificate	g phys	edic	d								
The law requires that the death certific	the attending p hed for use as	Physician/Me	in the past 12 months?	outcome pf pregna /e birth 2 □ Fetal egnant at time of de known	Ideath 3□	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	livery Day Year	
thatt	signed by the		Part II. Other significant conditions contributing t	o death but not resu	ılting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use contribute to	the cause of death?	
ouires	s been sign should be	ed by	delated Cardiomy	epally,	End	stage ru	al	1 U Y	es 2No 3□P	robably 4 □Unknown	
aw re	as bee	Completed	disease, Hyper	teurin	, Dro	abetes	nellite	24a. Was a	an 24b. Were a	utopsy findings available completion of cause of	
		Com	Mon Insulu dep	ce dent,	Smi	como ded	ystrence	perfor	rmed? death? 2 No 1 ☐ Yes	. 4	
cian	sertific ector,	Be (25. Was case referred to medical examiner? Hospital:			Otho		eath (Check only or	ле)		
Phys	ral dir	2	TE res ZA NO	Inpatient 2	ER/Outpatien 28b. Time of		4 🗆 Nursing	T	lence 6 Other (Spe	cify)	
ding C	th. : After	tion	1 X Natural 5 Pending (fl 2 Accident investigation	fonth, Day Year)	Injury	Worl	k? Yes 2 □ No	200. 2000/201	ow injury occurred		
Atte	er dea rector	Certification:	3 ☐ Suicide 6 ☐ Could not be 28e. Pl	ace of injury - At ho illding, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (S City or Tow	Street and Number or R	ural Route Number,	
oitalo	urs aff		One Codifice 1 Mondifular Physician T-	the heat of my keep	wlades dooth	a cocurred at the time	no data and place				
To the Hospital or Attending Physician:	within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	ledical				vestigation, in my o	pinion, death occ	curred at the time, o	date and place, and du	e to the cause(s)	
To I	To COUT	Z	29b. Signature and title of certiffer	tagi me	0	29c. License	9 number 4720	2	29d. Date signed (Mont		
2			30. Name and address of person who completed of 6/32 Land	, (23a) (Type,	Print) RAV	INDER	ND 2	15 TAG/ 0785		
÷	Sta Registr			2. Registrar's Signar	ture)					
					767						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 03 15:10 PM MARGIE ANN JACYNSKI 2009 /Medical 4c. County of Deat 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HICKMICO PAIN SULA 54/15/4/4 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12-30-1938 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Days Min 1 □ M 2 🛚 F MARYLAND 69 215-34-7294 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State show "natural", or items 23a or 28a-f shoved at Examiner must be notified at 1 Yes 2 No Director SUSSEX OCEAN VIEW **DELAWARE** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number US 19970 36416 SMITH DRIVE Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XX No If Yes, Give Year or Dates: 1 ☐ Never Married 2 👿 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE Specify: ģ 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CLEANING SERVICE BUSINESS OWNER and Mental Hygie Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARGARET THOMPSON CHARLES MORRISON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Irrportant: If Item 27 Is any Injury or other traughte. 36416 SMITH DR, OCEAN VIEW, DE. 19970 GERALD JACYNSKI/ HUSBAND Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Pages 1 SACRED HEART OF Place) JESUS CEMETERY 1 N Burial 2 □ Cer 4 □ Donation 5 □ C 3-19-08 DUNDALK, MARYLAND S ☐ Offer (Specify) 21. Signature of Fune 22. Name and Address of Facility
MELSON FUNERAL SERVICES, TLD.
WEST AVENUE, OCEAN VIEW, DELAWARE. 19970 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. 23a. Part1. Enter the dise shock, or heart failure Immediate Cause (Final disease or condition resulting in death) LOSTRIBIUM PIFFICILE COLITIS **Physician** /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pre 3 ☐ Ectopic pregnancy Month Year in the past 12 m 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 ☐ Probably 4 ☐ Unknown Be Completed Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autop performed 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Dispatient 2 ER/Outpatient 3□ DOA Certification: To 1 TYes 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a Certifier Medical

Division or Vital Records, P.O. Box 68760 To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director; After this certifics completely filled in by the funeral director, I BA 6

Registrar

31. Date filed (Month, Day, Year) State

29b. Signature and title of pertiner

DO062916

29d. Date signed (Month, Day, Year)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

pleted cause of death (Item 23a) (Type, Print) Name and address 1415 SOUTH PIODION SUITE B SAUSSHULY DO

8

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** MÄRCH 7:48 PM ALTON JACKSON 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HARLES LATA ENTER MEDICAL LUISTA If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral ™** M 2□ F Months Days Hours Min. **6**5 APRIL 11,1942 MARYLAND 218-38-8177 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County a or 28a-f show t be notified at show 1 X Yes 2 □ No Director MARYLAND CHARLES NANJEMOY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? UNITED STATES 20662 permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Merial Hygiene... Important: I fiem ZT Is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner musts b 4530 PORT TOBACCO ROAD by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) FEDERAL GOVERNMENT SUPPLY TECHNICIAN 12TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ALICE JACKSON WILLIAM HENRY BROWN ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4530 PORT TOBACCO ROAD, NANJEMOY, MARYLAND 20662 BELINDA BROWN / SISTER 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State THE CHURCH OF THE LOKO) 1 Burial 2 □ Cremation 3 □ Removal from State JESUS CHRIST APOSTOLIC FAITH 3/22/2008 IRONSIDIES, MARYLAND 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Ligo. ADIA C. THORNION JOHNSON MO0583 THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence **Examiner** 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page certificate 2 No 2 1 ☐Yes Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 KER/Outpatient 3 □ DOA ဥ After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: or Attending 1 Natural 2 Accident 5 Pending 1 □ Yes 2 □ No investigation death. the within 24 hours after death To the Funeral Director; 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division or Vital Records, Hospital

> State Registrar

DHMH 17 Rev 1/2001

filled in by

Medical

4 Homicide

(Check only

31. Date filed (Month, Day,

29b. Signature and title of certifier

Kati

Year)

MAR 1 8

2008

29a. Certifier

30. Name and address of person willo completed cause of death (Item 23a) (Type, Print)

29c. License number D-0061652

Suite 101

edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 death accurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month. Dav. Year)

6 POST OFFICE Road

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 0:05 AM 362008 Donald Kesner March /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany Lions Center for Rehabilitation Cumberland If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jan 30, 1937 . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral X** M 2 □ F Country) Months Director 232-54-4718 Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show notified at MD Allegany Cresaptown Director Y☐Yes 2☐No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or must be r 21502 USA 13728 Spruce Spring Road Funeral items 12. Was Decedent Ever in U.S. Armed Forces?

✓ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. d other than "natural", or iter event, the Medical Examiner 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify <u></u> Specify: 3√ Widowed 4 Divorced white Completed Kesner Jone Baltimore, Maryland 21215-0 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 State of Maryland <u>Youth Counselor</u> permit. Pages 1 and 2 should be filed I Department of Health and Mental Hygis Important: If item 27 is marked other I any injury or other traumatic event, ti 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Russell Kesner Alma (Williams) Kesner ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, MD 21539 19701 Jackson Mountain Lonaconing Marjorie Llewellyn step-daug. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 3/28/2008 Frostburg Memorial Park MD 4 Donation 5 Dother (Specify) Frostburg 21. Signature of Funeral Service Licen-22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Demonto **Physician** months End stuge /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter third-rights Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown cate has been sig page 2 should b Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 1∐ Yes 2 No 2 X No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

Josh Dr.

935 Bishopl

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

nunc

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State	of Marylan		artment of H		and M	ental Hy	giene	$Z \cap H \cap S$	10280
24		-0	Decedent's Name (First, Middle)	fle, Last)			timodito or i	- Journ		2. Date of De			3. Time of Death
	Physic		Elaine Swain	n Kieffe	. 20					Month March	11.	2008	8:42 a _M
	/Medi Examir		4a. Facility Name (If not institution				4b. City, Town, or	Location of		ilai cii		County of Death	
	LAGIIII	ici	Shady Grove A			1	Rockvil					lontgome	
A	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Year	If Under		8. Date of Bi	rth	9. Birth	place (State or Foreign
ì.	Director		578-05-4487	1□M 2 1 F	9	Yrs.	Months Days	Hours	Min.	(Month, D. 10/18		Cou	ington, DC
	D.		Usual Residence of Decedent							10/10	7 1 7 1 2	, wasii	ingcon, bo
	ırylar ihow	_	10a. State 10b. Count	y		, Town or Lo							10d. Inside City Limits
	e Ma Ba-f s	Director	MD Montg	omery	R	lockvil	le						1XYes 2 No
	or 28	Dire	10e. Street and Number				10f. Zip Code				10g. Citiz	en of What Cou	ntry?
	23a ust b		519 Carr Aveni	ie			20	850				USA	
	r deg	Funeral	11. Marital Status	Armed F	cedent Ever in U. orces?	S. 13. \	Was Decedent of Hi f Yes, specify Cuba	ispanic Orig	gin? (Spe	cify Yes or No	D- 1	 Race - Ameri Black, White. 	
36	s afte	by F	1 □ Never Married 2 ☑ Ma	rried 1 ☐ Yes If Yes, G	2 ⊠ No live		I∐Yes 2⊠No					Specify:	
215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ont, the Medical Examiner must be notified at	D D	3 ☐ Widowed 4 ☐ Divorce		Dates:	10a Dans	landa Usus I Ossa						White
5	n 72 i "na"	Completed	(Specify only high	nt's Education est grade completed)	(Give	lent's Usual Occupa kind of work done o OO NOT use retired	ation during most	t of workir	ng	160. Kin	d of Business/Ir	idustry
	withi ene. than	層	Elementary/Secondary (0-12)	College	(1-4or 5+)		maker	,			Dan	ivate	
0	filed Hygi sther		17. Father's Name (First, Middle	 , Last)		1101116	maker	18. Mothe	r's Name	(First, Middle			
Maryland 21	ould be Mental arked o	To Be	Clarence W. S	main								,	
2	should ind Men marke umatic	Ě	19a. Informant's Name/Relation			19b. Mailin	g Address (Street a			T. Ha		Town State Zin	n Code)
Ξ	and 2 sealth an 27 is ner trau		Mrs. Barbara Ca		ece		Carr Aveni					0850	0 0000)
saltimore,	- 구 등 도		20a. Method of Disposition		20b. P		sition (Name of natory or other place			ate		ation - City or T	own, State
ē			1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (i State				00/1	0.10000		_	
≣	permit. Page Department Important: If any injury or once.		21. Signature of Funeral Service		Ft.	Linco	oln Cemet	ery ;	03/1	8/2008	Bren	twood,	MD
ñ	Dep Dep Imp any		Source Monto		heat Ca	3/	01 Blade	nohum	r Po	Linco	ın Fu	neral H	ome, Inc. 20722
			23a. Part1. Enter the disease,									oa, m	
	Dhysisian		Immediate Cause (Final	t only one cause on	each line.			5 ,				- 1	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) a. Malignant Arrhythmia Due to (or as a consequence of):										
	Examiner		D										
В		ē	Sequentially list conditions, from Cause. Enter Underlying Cause (Disease or injury that initiated events		or as a consequ	ience of):						- 1	
	uted d ansit	Examiner	Cause. Enter Underlying Cause (Disease or injury	S .									
_	be executed ician and burial-transit	Exa	resulting in death) Last	Due to	(or as a consequ	ence of):							
2/07	cate be executed ohysician and the burial-transit	dical		d									
õ	certifica nding phi use as th	ledi											
X Q	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		itcome pf pregna birth 2 ☐ Fetal		Ectopic pregnancy				23	3d. Date of deliv	ery
D	0 0 0	sicie	in the past 12 months? 1 ☐ Yes 2 🖾 No	4□Preg	nant at time of de		Other (specify)					Month	Day Year
5	w requires that the de been signed by the should be detached	hys	9 ☐ Unknown	9∐Unkr	iown								
'n.	as the	by F	Part II. Other significant condit	ions contributing to c	death but not resu	Iting in the ur	derlying cause give	en in Part I.		23e. Did	tobacco us	e contribute to t	he cause of death?
5	en si									1 🗆	Yes 2□	No 3□ Proi	bably 4ื⊠Unknown
ecords,	B 25 0	Completed								24a. Was		24b. Were auto	opsy findings available
2	rsician: The law s certificate has b lirector, page 2 s	E								auto perfo 1∐ Yes	ormed?	death?	mpletion of cause of 2 No
N I I	lan: rtifica stor, p	Be C	25. Was case referred to medica	al				26. Place	of Death	(Check only		1 163	2 10
	nysic nis ce direc	ToE	examiner? 1 Tes 2 No	Hospital: 1 🔼	Inpatient 2 ☐ 8	ER/Outpatien	3 DOA Othe	or: 4□Nur	rsing Hom	ne 5□Resi	idence 6	☐Other (Special	fy)
5	ng Pl		27. Manner of Death 1 X Natural 5 ☐ Pendii	28a. Date	of Injury oth, Day Year)	28b. Time of Injury	28c. Injury Work			8d. Describe			,
2	ath. arth. or: At	atio	2 ☐ Accident invest	igation	, 2,	,,		res 2□N	No				
≝	er de	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 28e. Place	e of injury - At hor ling, etc. (Specify		et, factory, office		2	8f. Location (City or To		Number or Run	al Route Number,
5	ital o	Se							_				
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		(Check only 2 Medical	ng Physician: To the Examiner: On the b	e best of my know	vledge, death	occurred at the tim	ne, date and	d place, a	nd due to the	cause(s) a	and manner as s	stated.
	the I	Medical	oney	and mar	nner stated.					a at the tille.			
	on Son	2	29b. Signature and title of certifit	1.			29c. License	/				signed (Month,	M
^	P		Los (at M.	<i>Q</i> -		DUQ	5659	155		MAR	CH 11'	2008
11	(2)		30. Name and address of person	who completed cau	se of death (Item	23a) (Type, F	Print)	_	4			- ^	C-2-4
1			YOGIN PARE	9901	MEDICAL	CENT	Print) PRINTER DRIV	F	RO	CKUILLE	. ~	117 5	0850
	Sta		31. Date filed (Month, Day, Year, MAR 1 8 2008	32. F	registrar's Signa	ure .							
4	Registr	ar	WHY I O COOL	Done	N M								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month Wanda Darlene Kendall March 8005 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** Sina. Buttimore Baltimore Hos If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🗶 F Days Hours Director 213-62-5104 55 1953 Maryland Feb. 15, Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 No Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ò or items 23a 4139 West Forrest Park Avenue 21207 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🛛 No Completed by Specify. 3 Widowed 4 Divorced "natural" White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) caregiver child care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) To Be permit. Pages 1 and 2 should be fil Department of Health and Mental H Important: If Item 27 is marked otl any Injury or other traumatic even onee. Thelma Mae Miller Robert Lee Kendall, Sr 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Kendall, brother 3115 Ryerson Circle, Baltimore, Maryland 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 3/19/2008 Alexandria, Virginia 21. Signature of Fune al Service Lice 22. Name and Address of Facility Molesworth-Williams Funeral Home 26401 Ridge Road, Damascus, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) omplications Workid **Physician** /Medical Due to (or a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical as the IF FEMALE: detached for use If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 modths? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 1 ☐ Yes this certificate 2□No 2.□**/**No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 2 R/Outpatient 3□ DOA 1 ☐ Yes 1 | Inpatient Certification: To 28a. Date of Injury (Month, Day Year) within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27, Manney of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) and address of person who com ted cause of death (Item 23a) (Type, Print) SINA HOSDITAL 31. Date filed (Month, Day, 32. Registra Signature

DHMH 17 Rev 1/2001

State

Registrar

Year)

2008

Ban

			For State of Management State of Management State State of Management State of Managem	aryland / Depa <i>Cei</i>	artment of He rtificate of D	ealth and Me D <i>eath</i>	ntal Hygie Reg.		10282	
r	Physici	an	1. Decedent's Name (First, Middle, Last)				. Date of Death		3. Time of Death	
	/Medic	cal =	MARY LOUISE KENNEDY		4h Cihi Taura and		ARCH 1	1 7 2 0 0 8 4c. County of Death	12:10P ^M	
	Examir	er -	4a. Facility Name (If not institution, give street and number) HCR MANOR CARE		4b. City, Town, or I			MONTGOM:		
The second	Funeral Director		263-36-1027 1□M 2¶F	e (In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	Hours Min.	Date of Birth (Month, Day, Ye UNE 15	ay, Year) Country)		
	land		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits	
	Mary a-f sho ified a	ctor	MD MONTGOMERY	POTOMA	AC				1 □Yes 2 WNo	
	with the a or 28 be not	Director	10e. Street and Number 10714 POTOMAC TENNIS	T.ANE	10f. Zip Code 20854		10g	. Citizen of What Cou USA	intry?	
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medion Examinar must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced 1 ☐ Yes, Give Year or Dates:	Ever in U.S. 13.		spanic Origin? (Speci h, Mexican, Puerto Ri Specify:	fy Yes or No- can, etc.)	14. Race - Amer Black, White Specify: WH	, etc.	
215-0036	72 ho "natur	eted	15. Decedent's Education (Specify only highest grade completed)	ı (Give	dent's Usual Occupa kind of work done du	urina most of workina	16	b. Kind of Business/li	ndustry	
2121	within iene. than " the Mec	Completed	Elementary/Secondary (0-12) College (1-4or 9	5+) l	DO NOT use retired) JSEWIFE		1	DOMESTIC		
Maryland 2	ould be filed Mental Hygi arked other atic event, tl	Be	17. Father's Name (First, Middle, Last) ROY A. BEERS	'		18. Mother's Name (I		iden Surname)		
aryl	2 should land Men is marker aumatic	오	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street a	nd Number or Rural I	Route Number, C	City or Town, State, Z	ip Code)	
	1 and 2 Health a em 27 is ither trai		LARRY KENNEDY / SON				·		MD 20837	
Baltimore,	permit. Pages 1 a Department of Hes Important: If Item any Injury or othe		20a. Metyrod of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		sition (Name of matory or other place NCOLN CE	- 3/24	/08	c. Location - City or 1 ${ t RENTWOOD}$		
Balt	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee	22	2. Name and Address HILTON	s of Facility FUNERAL X 86, BA	HOME		20838	
	AL.		23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each li	,	Approximate Interval Between					
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. UROSE						Onset and Death	
	Examiner		Due to (or as	a consequence of): OENTERIT	IS					
В	p _e tis	iner	Sequentially list conditions, if any loan 15 immediate cause. Enter Underlying HYPOK	a consequence of:						
60,	eath certificate be executed attending physician and for use as the burial-transit	al Examine	that initiated events resulting in death) Last C	a consequence of):	JCTIVE P	ULMONARY	DISEAS	SE		
68760,	ficate I physics the t	edical	d							
P.O. Box	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 ☐ Fetal death 3 ☐	□Ectopic pregnancy □ Other (specify)			23d. Date of deliver Month	very Day Year	
	uires that signed by d be deta	þ	Part II. Other significant conditions contributing to death b	ut not resulting in the u	nderlying cause giver	n in Part I.		cco use contribute to	./	
Vital Records,	The law requi ate has been s bage 2 should	Completed					24a. Was an autopsy performe	24b. Were aut	topsy findings available ompletion of cause of	
/ital		BeC	25. Was case referred to medical examiner?			26. Place of Death (1110	2 110	
or \	Physic this cral dire	은	1 Yes 2 No Hospital: 1 Inpatie			4 Nursing Home		ce 6 ☐Other (Spec	ify)	
lon	ding J. After funel	tion	1 Natural 5 Pending (Month, Da 2 Accident investigation		Work'	es 2 □ No	d. Describe how	injury occurred		
Division	l or Attend after death Director: A	Certification:	3 Suicide 6 Could not be 28e. Place of inj	ury - At home, farm, str c. (Specify)	reet, factory, office	28	f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,	
	To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st	f examination and/or in						
	Mithi To t	M	29b. Signature and title of certifier	10 (1)	29c. License		1	. Date signed (Month		
	0		30 Name and officers of paragraphs appropriated	looth (Itom 22a) (Time	D202	/ 4	1	MARCH 17	, 2008	
	9		30. Name and address of person who completed cause of c	10 BRADLE		ВЕФивес	DY WD	20817		
	Sta		24 Date filed (Month Day Voor) 22 Pagint	hr's Cianatura		,— <u></u>	un, PID			
	Registr	ar	MAR 1 8 2008		7					

DHMH 17 Rev 1/2001

08-0228	9
Paula L.	Kennedy

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008	0283
------	------

		or State istrar			Certi	ficate of	Death			R	eg. No.			
Physician	1. [ecedent's Name (First, Mi	ddle,Last)						2	. Date of Dea	th	Vasa	Time of Death	,
Medical Examine		Paula Lee								Month March 23,	Day 2008	Year	0545 hrs	
a		Facility Name (if not institu		t and number)		4	b. City, Town,	or Location	of Death			inty of Death		
		33B Owens Landing	Road				Perryville				Cecil			
Funeral	5. S	ocial Security Number	6. Sex	7. Age	(In yrs. last	t birthday)	If Under 1 Y		der 24Hrs.	8. Date of Bir	th(MM/DD/Y	YYY) 9. Birti Foreigi	place (State or	
Director	2	17-64-4487	1 1 M 2	2 x F	52	Yrs.	Months D	ays Hou	rs Min.	June	12,19	955 cou	ntry) MD	
	Usu	al Residence of Decedent												
any	10a	. State 10b. Cour	ty		10c. City, To	own or Location	on						10d. Inside City	Limits
ihow	_	MD Cec	·i 1		F11	kton							1 Yes 2 🕽	X No
arylan	ည် 10e	. Street and Number			11.1	it com	10f. Zip Code			1	0g. Citizen o	of What Coun	try?	
or 21	10e	40.46 m-1-		- 1			219	21					S.A.	
123a	. I	4346 Tele		RQ •	Ever in II S	13 1/12	Decedent of		rigin? / Spo	oifu Voc or No	114 5		an Indian, Black,	
items ath w	11. 1 [Never Married 2 3		Armed Forces?			es, specify Cul					White, etc.	all Iligiali, Diack,	,
er de			1 Divorced If Yes,		No	1	Yes 2x No specify: Specify: W					cify: Wh	ite	
ural min		i. Decedent's Education (S	or Dat	es.	pleted) I 1		's Usual Occu			rk done		of Business/Ir		
2 hou "nat	ڇَا پَڍِ	Elementary/Secondary (0-1		ollege (1-4 or 5			st of working						,	
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica		12	,	_	´	C	ashie	_			Acr	ne		
d will	5 17.	Father's Name (First, Mide	dle, Last)						er's Name (First, Middle,	I Maiden Surn	name)		
215 e file tal H ked o		H. Linton	Revnol	lds				F	au1i	ne Pe	terso	วท		
21 build b Men mar		. Informant's Name/Relation				19b. Mailing	Address (St						Zip Code)	
d 2 sho d 2 sho lth and n 27 is aumati	H	arold Stev	en Ker	nnedy/	Husb	and .	4346	releg	raph	Rđ.,	E1kto	on, M	D 2192	21
	20a	. Method of Disposition			20b. Pla	ce of Disposi	tion (Name of		T	Date	20c. Loca	tion - City or		
altimore, rmit. Pages I ar epartment of Hee portant: If ite	1	X Burial 2 Crema		moval from Sta	16	ematory or oth lpin				ch 27	F 1	lkton	. MD	
it. Partiment you	4	Donation 5 Other Signature of Meral Serv	Specify:		GI.		ame and Addr	one of Engil		80	15.	LKCOII	, 11D	
Balt permit. Departu Import injury	218	Signalar dir Heral Serv	ce Licensee				ndrew			unera	1 Hor	ne		
Physician	23a	. Part I. Enter the disease,	or complication	ns that caused	he death. D	o not enter in	50 F	Mair	Cardiac of	Elkto	n MI	2,19	n proximate Ir	nterval
Physician /Medical	200	failure. List only one cau	se on each line).			ic mode or dyn	ig, 5 6 611 45	odraide or	respiratory an	cot, shook, c	or ricure	Between Onse	
⊂xaminer		Immediate Cause (Final disease or condition resulting in death) a. Epicarditis and Pleuritis Due to (or as a consequence of):										Death		
			Due to	(or as a conse	quence ot):									
3		quentially list conditions, ny, leading to immediate	Due to	(or as a conse	guence of):									
	Cau (Dis	se. Enter Underlying Causease or injury that initiate	se _											
ted Insit	eve	nts resulting in death) La		(or as a conse	quence of):									
and and tran			d	- 00	07		1/10/05							
3760, ficate be executed g physician and stree burial - transit		UNPENDED	AME	NDED 23a,	2/ per	ME g8/8	4/10/08	amh						ļ
8760, tificate be ng physici as the buri	IF F	EMALE: Was decedent pregnant in		. If yes, outcom								te of delivery		
ox 687 eath certific attending process to		past 12 months?		Live birth Pregnant at		h 🗀		3Ector	oic pregnan	су	Mor	nth D	ay Yea	ar
Box 68 Re death certi the attendin ted for use as	Pari	Yes 2 No 9	Jnknown g	Unknown	inc or dead	n 5 Oth	ner (Specify)							
Vital Records, P.O. Box 68 ysician: The law requires that the death certif his certificate has been signed by the attending director, page 2 should be detached for use as De Committed by Dhusician	Pari	t II. Other significant con			but not resu	ulting in the u	nderlying caus	e given in I	Part I.	23e. Did t	obacco use	contribute to	the cause of deat	ith?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the start death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach but the funeral director, page 2 should be detach but Defendent but Def	<u>a</u>	_		J		·	, ,	J		1 Ye	s 2 No	3 Prob	ably 4 🗸 Unkr	nown
duire signal by the bod	Completed									24a. Was	an 2	24h Were au	topsy findings av	/ailable
Orc aw re tas be										auto			ompletion of caus	
Rec The I	<u> </u>									1 Yes		1 🗸 Ye	s 2 🔲 I	No
tal Fician:		Was case referred to med examiner?					26.Pl		h (Check or	nly one)				
FVit Physic or this c	0	1 ✓ Yes 2 No	Hospital	1 Inpatie	nt 2 E	R/Outpatient	3 DOA	Other ₄	Nursing	Home 5	Residence	6 🗸 Other	: Scene	
Toff ding Ph	27.	Manner of Death	28	Ba. Date of Injui	y 2	8b. Time of Ir	njury 28c. I	njury at Wo	rk? 2	28d. Describe	how injury o	ccurred		
ion tendi	1 2	_ J _ P	ending	(,,			1	Yes 2	No					
ivisior or Attenc after death Director: I in by the	≝ ²		vestigation 28	8e. Place of Inj	ury - At hom	e, farm, stree	t, factory, offic	e building,	etc. 2			lumber or Ru	ral Route Numbe	er, City
Division 6 spital or Attending tours after death. neral Director: After filled in by the fune	4			Specify)					- 9	or Town,	State)			
Hosp 24 ho Func tely f			Physician: To											
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certivitin 24 hours after death. To the Funcral Director: After this certificate has been signed by the attendint completely filled in by the funeral director, page 2 should be detached for use a Medical Certification: To Be Completed by Dhysician	one)		xaminer:On the	e basis of exan	nination and	/or investigat	on, in my opin	ion, death o	occurred at	the time, date	and place, a	and due to the	e cause(s)	
F × F × S	29b	Signature and title of cert		stated.			29c. Lice	ense numbe	er		29d. Date	signed (Mor	nth, Day, Year)	
		Chro De					0.	C.M.E.			March :	26, 2008		
	30	Name and address of pers	on who comple	ted cause of de	eath (Item 2	3a)								
			ssistant Me				treet, Balti	nore, Mi	21201					
Stat		Date filed (Month, Day, Yea		32 Registrar				·						
Registra	.c	MAR 3 1		F. Pagosa	· K	Low	18.1							
DHMH 17 Rev 1/2001	1		-	-	9	ORIGINAL								
00145 0000						J. WOUNT	-			CARE				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 24 1323 2008 KOENIG 03 FRANK /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not Institution, give street and number) Examiner CUMBERLAND ALLEGANY MEMORIAL HOSPITAL 8. Date of Birth (Month, Day, Year) Feb 26, 1937 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Months Days Hours Min. Germany **Director** 217-38-8033 Usual Residence of Decedent 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 Yes 2 No MD Allegany Cumberland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or Items 23a or the Medical Examiner must be 21502 711 Princeton Street USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Be Completed by Specify: 3 Widowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Il Hygiene. College (1-4or 5+) 12 High Q Inc. Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) es 1 and 2 should be fi of Health and Mental H fitem 27 is marked otl r other traumatic even Fritz Koenia Barbara Litterscheid 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21502 wife 711 Princeton Street Cumberland Martha Scherr of Health a Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State = 5 permit. Page Department o Important: If any injury or 3/28/2008 **Ebenezer Cemetery** WV Romney 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Finneral Ser 108 Virginia Avenue: Cumberland, MD 21502 22a Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MYCCARDIAL INFARCTION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or an a consequence of) Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, by Physician/Medical ending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Day in the past 12 months? Month Year 4⊡Pregnant at time of death as been signed by the a 2 should be detached t 1 Yes 2 No 9□Unknown 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy certificate ha performed? Yes 2 No 2 No 1□ Yes 1 ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred After Certification: (Month, Day Year) 5 Pending Injury ithin 24 hours after death.

o the Funeral Director: Af
nmoletely filled in by the ful M 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifler 0 D54004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

SHIV

31. Date filed (Month, Day, Year)

KHANNA, M.D.

2008

MAR 3 1

1221-E NATIONAL HIGHWAY LAVALE MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [1] 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 23 2008 A^{M} March 0630 Gary John LaRock /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cecil 7 Radcliffe Court E1kton | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | July 17, 1942 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**∑**M 2□F 084-34-2815 65 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 ☐ No Director Maryland Cecil Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? . 23a r 21921 United States 7 Radcliffe Court Funeral 12. Was Decedent Ever in U.S. Armed Forces?

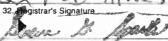
1 XX Yes 2 No If Yes, Give Year or Dates: 1960 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1960-1 Never Married 2 Married 0 21215-0036 1 ☐ Yes 2 No 1966 Specify: þ 3 ☐ Widowed 4 ☐ Divorced White "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry United States ges 1 and 2 should be filed within t of Health and Mental Hygiene. If Item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Government Electrical Engineer/Consultant Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frank LaRock Laura Schaefer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly W. LaRock/Wife 7 Radcliffe Court, Elkton, MD 21921 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition March 24. 20c. Location - City or Town, State permit. Pages 1
Depertment of H
Important: If ite
any injury or ott 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R. A. Ferris & Co., Inc. West Chester, PA 21. Sign ture of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, 21921 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause, on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) the th be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? hes autopsy performe 2 No 1 ☐ Yes 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 10 1 Inpatient 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation i Director: / 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funeral Dire Medical 💆 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

MAR 3 1 2008



30. ame and address of person who completed cause of death (Item 23a) (Type, Print)

				Please ⁻	Type or Prin									ible.	
		-	For State Registrar AM	END#29dperMC	State of Ma 3/24/08,BMW	-		epartme <i>Certifica</i>			na ivien		ene g. No. 2	08	10285
0			1. Decedent's Nan	ne (First, Middle, Las	t)							Date of Death Month	Day	Year	3. Time of Death
368 Marie	Physicia /Medic			Ceceli	la Constan	ce M	ichae	els				rch	13	2008	2250 M
	Examin	er		'If not institution, give			4b. City, Town, or Location of Death					4c. County of Death			
				mery General		- //	46:0	/) If I Inc	O: er 1 Year	Iney If Under 24	4 Ure To	Date of Birth		Montg	pplace (State or Foreign
12	Funeral Director		5. Social Security 141-10-7	¹ [580	7. Ag	e (In yrs. la	Months Days Hours Min. (Month, D						22, 1918 New Jersey		
	and w	-	Usual Residence of 10a. State	10b. County		10c. City,	Town o	r Location							10d. Inside City Limits
	//anyla f sho ed at	o	Maryland	Montgor	no eu				S.	ilver S	nrino				1 ☐ Yes 2 👿 No
	the N 28a-	Funeral Director	10e. Street and No	<u>-</u>	iici y			10f. 2	Zip Code	LIVET O	br tP	10	g. Citizen of	What Cou	untry?
	3a or	Ö	33	364 Glen Eagl	le Drive. #2	-E				2090	6			U.S	.A.
	ms 2: mus	era	11. Marital Status	or oton mag.	12. Was Decedent	Ever in U.S	6.	13. Was Dec	edent of H	lispanic Origi an, Mexican,	in? (Specify	Yes or No-			ican Indian,
(0	or ite		1 Never Mai	ried 2 Married	Armed Forces? 1 ☐ Yes 2 🛣				2 II No		, Puerto Hica	an, etc.)		ck, White	e, etc.
03	ral", c	by	3 X Widowed	4 ☐ Divorced	If Yes, Give Year or Dates:			1 LI Tes	ZELINU	эреспу.			Speci	ry:	White
215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene. If Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed	(Spe	15. Decedent's Ed	ucation de completed)	1	16a. D	ecedent's U	sual Occur work done	oation during most d)	of working	1	6b. Kind of E	Business/I	ndustry
2	within lene. than " he Med	np[u	Elementary/Sec		College (1-4or 5	5+)	`II			•			Post.	oroide	
21	filed w Hygiel other tl		47. Fathar's Name	(First Middle Loot)				Machine	e Uper		'e Nama /Fi	rst, Middle, M			il y
and Ind	be fill	Be		(First, Middle, Last)						10. WOULE		eve Coll		ine)	
Maryland	should be f and Mental H s marked of umatic ever	၉		inick Musto	ione (Print)		10b B	foiling Addre	on /Stroot	and Number		oute Number,		Stata 7	in Code)
Mai	12 sho h and I 7 is ma trauma			Name/Relationship (7				•				Spring,			
	1 and 2 Health lem 27		20a. Method of Dis	W. Michaels	- 3011	20b. Pla		isposition (A			Date		Oc. Location		
Baltimore,	0 0 - F		1 🗷 Burial 2	Cremation 3		h				!	02/10/2		Cilvon	Comin	g, Maryland
臣	permit. Pag Department Important: I any injury o	-		5 ☐ Other (Specify funeral Service Licen	·	Gat		Heaven 22. Name		ery ess of Facility	03/18/2	2008	211ve1	Sprin	ig, rial yland
Ba	permit. Departr Importa any inju		▶ N	A	VI		ر	Hines-	Rinald	i Funer.	al Home	Inc.	r Sprine	o Mar	ryland 20904
	POLE DA		23a. Part1. Enter	the dise se, or comp	olications that caused	d the death.								5, 1411	Approximate
		U	shock, or he Immediate Caase	a List only	one cause on each li	ne.	n.			A				ļ	Interval Between Onset and Death
)	Physician /Medical		disease or conditi resulting in death	on	a. Due to (or as	7tt	PA	EUM	1001	/					
	Examiner			- 6	OF	010	A 7	PN	FA	7,12	+				
	20	ler	Sequentially list of if any, leading to	onditions, mmediate	b. Due to (or as	a consequ	ence of)	:	141	1001					
	uted d ansit	Examiner	cause. Enter Und Cause (Disease of that initiated even	periying or injury ts	. /	181	281	-p58	25						
o,	exec an an rial-tr	Exa	resulting in death)	Last	Due to (or as			1		2 11		1 7-		,	
9289	eath certificate be executed attending physician and for use as the burial-transit	cal		•	d. A 17	HER	05	cli	108) C #	ZARI	DISE	ASC		
9	rtifica ng ph as th	Physician/Medica	JE ECNAN E.												
Box	th ce rendir	an/h	IF FEMALE: 23b. Was decede	nt pregnant	23c. If yes, outcome 1□Live birth			3 □Ectopio	pregnanc	:V				ate of deli	ivery Day Year
	e dea	sici	in the past 1 1 ☐ Yes 2	□ LNo	4□Pregnant a 9□Unknown			5 ☐ Other	(specify) _				10	ionin	Day Teal
P.0	at the by the	بأ	9 □ Unknow				W t - 4	to a considerate design		in Book I		00a Did tah	2000 1100 00	ntributo to	the cause of death?
Records,	The law requires that the death certificate be executed ate has been signed by the attending physician and agge 2 should be detached for use as the burial-transit	þ	Part II. Other sign	nificant conditions of	onthbuting to death b	out not resu	iting in ti	ne unaeriyin	g cause giv	ven in Part i.		1 ☐ Ye	. /	3 □ Pr	
00	s bee	Completed										24a. Was ar		. Were au	itopsy findings available
Re	The la	ᇤ										autopsy perform 1∐ Yes 2	ned?/	death?	completion of cause of 2□ No
Vital		Be C	25. Was case refe	erred to medical						26. Place	of Death (C	heck only one		1 = 100	
>	Physiclan: The law this certificate has tral director, page 2 s	To B	examiner? 1 ☐ Yes 2[110	Hospital: 1 Dipatio	ent 2 🗆 E	ER/Outp	atient 3	DOA Oti	her: 4 Nur	rsing Home	5 🗆 Reside	nce 6 □O	ther (Spe	cify)
Or	<u>a</u> = <u>a</u>		27. Manner of Dea		28a. Date of Inju	ury av Year)	28b. Tir	ne of ury	28c. Inju Wo	iry at	280	I. Describe ho	w injury occi	urred	
Ö	Attending r death. ector: After by the funer	atio	1 □ Natural 2 □ Accident	5 Pending investigation		, , , ,	,	М]Yes 2□N	No				
Division	or Attendater death Director:	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	200, Flace Ul III	jury - At hoi tc. <i>(Specify</i>	me, farn	n, street, fac	ory, office		28f.	Location (Str City or Town		nber or Ru	ural Route Number,
	tal or rs after al Dir	Ce								_					
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director:		29a. Certifier (Check only		ysician: To the best niner: On the basis o	of examinat									
	To the I within 2. To the I complet	Medical	one) 29b. Signature ar	ad title of cortific	and manner st	tated.			29c Licen	se number		20	9d. Date sign	ned/(Mont	th Dav. Year)
		-	29b. Signature at	id tille of certain	2	1/				622	65	-	7/10/	120	10-5-1
	7			M. S.			00 \ ~		VOC	0 20	- 0,5	10	>117	100	18 11
				dress of person who					torm	Marvelan	nd 2177	n			
	Sta	ate.	Sadik 31. Date filed (Mo	M. Ali, M.D. onth, Day, Year)	32 Regist	rar's Signat	ture	nagers	LUWII,	rial y Lan	IG Z1/4	<u> </u>			
	Registi		M	AR 17 20	08 Som	J 1	1	porte	9						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 🛭 🗎 💍 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician Month Year P^{M} William D. Mitchell March 15, 2008 3:44 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Homewood at Crumland Farms Frederick Frederick 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 DMM 2□ 346-26-0611 75 July 20, 1932 Ohio Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d Inside City Limits 10b. County 1 ☐ Yes 2X No Director Maryland Frederick Frederick 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7407 Willow Road 21702 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? 195 1 Xes 2 No If Yes, Give Year or Dates: 195 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1955-1 □ Never Married 2 □ Married 1 ☐ Yes 2 No 1958 Specify: White \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ <u>Biochemist</u> <u>Horticulture</u> 18. Mother's Name (First, Middle, Maiden Surname) Be

17. Father's Name (First, Middle, Last) William Mitchell

Funeral

Director

28a-f show be notified

'natural", or items 23a

permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Examiner must

Physician

/Medical

Examiner

burial-tran and

The law requires that the death certificate be executed

P.O. Box 68760.

or Vital Records,

Division Hospital or Attending ည

Examine

Physician/Medical

þ

Completed

P

Certification:

Baltimore, Maryland 21215-0036

with ò

Norma Arnold

19a. Informant's Name/Relationship (Type. Print) Monica Muir / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8405 Stonehouse Rd., Frederick, MD 21702

20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ∑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) White Chapel Cemetery 3/20/2008 22. Name and Address of Facility

Troy, Michigan Stauffer Funeral Home

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

1621 Opossumtown Pike, Frederick, MD 21702 23a. Part1. Enter the discountry or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last resepo

Due to (or as a co equence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 ☐ Unknown

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death 9☐Unknown

3 ☐ Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Day

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

26.	Place	of	Death	(Check	only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 🗌 No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) 32. Registra

State Registrar

After

Director:

death.

DHMH 17 Rev 1/2001

ORIGINAL

within 24 hours a To the Funeral I 17

3 Suicide 4 Homicide

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☐ No

27. Manner of Death

1 🖳 Naturai

2 Accident

29a. Certifier

6 ☐ Could not be

5 Pending investigation

and manner stated.

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Margaret Louise Miller March 12 2008 M 9:40A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 213 Holly Road Edgewater Anne Arundel 9. Birthplace (State or Foreign Country) West Virginia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov 25 Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Days 1 ☐ M 2 🖾 F 83 Nov 579-34-8546 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Anne Arundel Director Edgewater Maryland 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 213 Holly Road 21037 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ĒNo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🗓 No Specify. Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk n and Mental Hygiene. Grocery Store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Georgia Lee Snyder Brown unknown ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is n any injury or other traun once. Martha Ward/ daughter 213 Holly Road; Edgewater, Maryland 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State March 14 2008 Ridgely Cemetery Ridgely, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Fleegle and Helfenbein Funeral Home, PA PO Box 160; Greensboro, Maryland 21639 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final year disease or condition resulting in death) Due to (or as a consequence by Physician/Medical Examiner

Physician /Medical Examiner

should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

page 2

attending physician and has certificate After this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral

Be Completed

Certification: To

29b. Signatur

or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, featuring to the cause. Enter Underlying Cause (Disease or injury that initiated events	uperica a an re) of euc.	ance off:					
resulting in death) Last	Due to (or as a consequ	ence of):					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	oc. If yes, outcome pf pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 Ectopic pr			23d. Date of deliv Month	very Day Year	
Part II. Other significant conditions cont	tributing to death but not resu	Iting in the underlying ca	ause given in Part I.	23e. Did tobacco	use contribute to t	the cause of death?	
Failure to	Venumia a	nd Ulina	y Jufector	24a. Was an autopsy performed?	prior to co death?	opsy findings available ompletion of cause of	
25. Was case referred to medical personal		26 Place of De	ath (Check only one)				
1 Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient 3 ☐ DO	A Other: 4 ☐ Nursing I	Home 5 Residence	6 □Other (Speci	ify)	
27. Manner of Death Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of lnjury M	8c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	ury occurred		
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At hoo building, etc. (Specify			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	ician: To the best of my know er: On the basis of examinat						

29c. License number

29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

262

and ma

Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-02213 State of Maryland / Department of Health and Mental Hygiene Cornelius McMillian Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Month Day March 19, 2008 Physician/ 2002 hrs CORNELIUS MCMILLIAN Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Clinton Southern Maryland Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 24Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Months Days Hours Min. WASHINGTON, DC 06/07/1980 Director 217-15-5267 1X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1XX Yes 2 No PRINCE GEORGES OXON HILL MD ral", or items 23a or 28a-f show iner must be notified at once. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20745 2105 ALICE AVENUE APT.# USA 203 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 11. Marital Status

1 Never Married 12. Was Decedent Ever in U.S. Was Deces? Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. BLACK Specify Yes 2 X No specify: permit. Pages I and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", o injury or other traumatic event, the Medical Examiner n If Yes. Give Year Divorced \$ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) 21215-0036 1 YEAR GOLF ATTENDANT PRIVATE 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LOUISE WILLIAMS HENRY MCMILLIAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2105 ALICE AVENUE APT. #203 OXON HILL, MD 20745 timore, MD LOUISE BLOUNT/MOTHER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a Method of Disposition

1 X Burial 2 Cremation 3 Removal from State crematory or other place) 03/27/2008 CLINTON, MD RESURRECTION CEMETERY Donation 5 Other Specify: 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 21. Sig ture of Funeral Servi License M 7474 LANDOVER ROAD LANDOVER, MD 20785 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician failure. List only one wase on each line Death **Medical** Peritonitis complicating perforation of large bowel immediate Cause (Final disease ∡aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Finneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Physician/Medical AMENDED 23a,27,per ME g878 4/15/08 amh X UNPENDED 23d, Date of delivery Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy Month Year 3b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Records, P.O. 1 Yes 2 No 3 Probably 4 V Unknown à Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed? 1 🗸 Yes 2 No No Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Hospital: 1 Other 4 Nursing Home 5 Residence 6 Others Inpatient 2 V ER/Outpatient 3 DOA 1 ✓ Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 1 Yes 2 No 1 X Natural Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be or Town, State) Suicide determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

9 30

State 31. Data filed (Month, Day Year NAR 2 5 2008

32. Registrar's Signature

Deputy Chief Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

March 20, 2008

			State of Maryland / Dep			20 00 00	10200	
		10	1. Decedent's Name (First, Middle, Last)	ertificate of Death	2. Date of Dear	eg. No.	3. Time of Death	_
E	Physicia		Norma Rae Otter		Month	Day Year 2008	1130 A M	
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat		_
	LXumm		Union Hospital	E1kton		Cecil		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 1 □ M 2 ☑ F Yrs.) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day	, Year) 9. Birt	thplace (State or Foreign buntry)	
	Director		175-24-6619 To Arrival Residence of Decedent		SEPT 16	, 1930 Dist	rict of Columbi	a
	land ow		10a. State 10b. County 10c. City, Town or I	ocation			10d. Inside City Limits	_
	Mary a-f sh ified	호	Maryland Cecil Elkton				1 X Yes 2 □ No	
	th the or 28; e not	Director	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What Co	ountry?	
	ath w	Funeral (103 Cow Lane	21921		United S		
	er de	ine	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit		
36	ırs aft Il", or xaml	by F	1 Never Married 2 Married 1 Yes 2 NN No If Yes, Give 3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 🔀 No Specify:		Specify:	<i>W</i> hite	
9-0	'2 hou natura ical E	ted	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation	kina	16b. Kind of Business		
215	ithin 7 ne. nan "r Med	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of wor DO NOT use retired)	1			
121	led w tygier her th		11 Sa 17. Father's Name (<i>First, Middle, Last</i>)	les Representative		Cosmetic Maiden Surname)	S	_
anc	d be fi	Be	Charles Carter		Stewart	maiden Gamaine)		
Maryland 21215-0036	should nd Me mark imatle	ဥ		ling Address (Street and Number or Ru		r, City or Town, State, .	Zip Code)	_
M	nd 2: alth al 27 is or trau		Edward Otter/Son 1704	Camden Avenue, Sa	alisbury	, MD 21801		
ore,	es 1 a of Hea litern		20a Method of Disposition 20b, Place of Disp			20c. Location - City or		
<u> </u>	Page nent o		4 □ Donation 5 □ Other (Specify) R. A. Ferr	is & Co., Inc. 2008		West Chest	er, PA	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility licks Home for Fund 03 W. Stockton Sta	erals, P	.A.	21921	
	9.63		23a. Part1. Inter the disease, or complications that caused the death. Do not e shock, it heart failure. List only one cause in each line.				Approximate	-
	Physician		Immediate Cause (Final disease or condition				Interval Between Onset and Death	
	/Medical		resulting in death) a. Due to (or as a consequence of):					_
8.5	Examiner		Sequentially list conditions. b.					_
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Lause (Disease or injury					
mg.	xecut and al-tran	хап	that initiated events resulting in death) Last Due to (or as a consequence of):					_
8760	cate be executed physician and the burial-transit	dical E	d					
9	tificate ig phy as the	ledic			1.55			-
Box	th certific tending p	an/N	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3	□Ectopic pregnancy		23d. Date of de	livery Day Year	
	w requires that the death certific been signed by the aftending p should be detached for use as	Physician/Med		Other (specify)		Month	Day real	
P.0	requires that the een signed by the rould be detache		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did to	bacco use contribute t	o the cause of death?	_
ds,	signe d be	d by	Stage 4 Chronic renal failure	, ,	1 □ Y	es 2□No 3□P	robably 4 Unknown	
202	law req as been 2 shoul	lete	Diabetes Mellitus		24a. Was a		utopsy findings available	
Re	siclan: The lar certificate has rector, page 2	Completed	(000			sy prior to death?	completion of cause of s 2□ No	
ital	an:] rtificat tor, p	BeC	25. Was case referred to medical	26. Place of Der	ath (Check only or		5 2 140	_
>	ding Physician: After this certific funeral director,	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati	ent 3 DOA Other: 4 Nursing H	lome 5□Resid	ence 6 □Other (Spe	ecify)	
ō	ing Pl	ü	27. Manner of Death 1 ✓ Natural 28a. Date of Injury (Month, Day Year) 28b. Time (Injury)	Work?	28d. Describe h	ow injury occurred		
sio	ttendi leath. ttor: A	cati	2 Accident investigation	M 1 Yes 2 No	29t Logation (C	treet and Number or F	tumi Pouto Number	_
Division or Vital Records,	l or A after d Direc	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)	treet, radiory, office	City or Tow		urar rioute rumber,	
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, I		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de					-4
	he Ho in 24 h he Fu pletel	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	nvestigation, in my opinion, death occi	urred at the time,	date and place, and du	e to the cause(s)	
	To t To t	Σ	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mon	th, Day, Year)	
			Voverce //artexea ret	DU053675		3/26/08		_
	2		30. Name and address of person who completed cause of death (Item 23a) (Typ Robert A. Monteleone, MD. III U	e, Print). D. High St. Suite 21	4. E1K1	tan mo 2	1921	
33	Sta	ate	31. Date filed (Month, Day, Year) 32. egistrar's Signature	P W.	.,,			_
	Regist		MAR 3 1 2008	ands)				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** RAPHAEL OLAWOYE 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner DOCTORS HOSPITAL PRINCE GEORGES LANHAM Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign APRIL 26,1941 LAGOS, NIGERIA 6. Sex 7. Age (In yrs. last birthday **Funeral** Days Months Hours 1 ☑ M 2 □ F 153-38-9248 66 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1√2 Yes 2 □ No CA SAN FRANCISCO notified Director SAN FRANCISCO 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number "natural", or items 23a or 1762 OAKDALE AVENUE 94124 NIGERIA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No BLACK Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry item 27 is marked other than "natu other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 4 YEARS ACCOUNTANT PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ ABRAHAM OLAWOYE FADNIPO UNAVAILABLE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HENRY AKINNAWO/NEPHEW 1810 MEZROTT ROAD ADELPHI, MD of Health 20783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date ortant: If it 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Important: It any injury o 4 □ Donation 5 □ Other (Specify) ST. ANDREWS CEMETERY 04/22/2008 LAGOS, NIGERIA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J.B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ERMINAC GLIOBLASTOMA **Physician** /Medical Due to (or as a consequence of): **Examiner** IABETE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) physician a Division or Vital Records, P.O. Box 68760, Physician/Medical as attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9∏Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Ulak 1 ☐ Yes certificate has been si rector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 4 1 ☐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Doe 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director; 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Discompletely filled in 1 Defifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

of D

State 31. Date filed (Month, Day, Year)
Registrar MAR 1 8 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 9:15 P M LOUISE MARGARET 24 2008 /Medical MARCH 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year, 4 - 1 - 1 9 2 4 Year If 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Davs Hours Min. 1 M 2 K 83 Director 577-40-6452 Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21702 Funeral 8020 Glendale Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2√€ No Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n; any injury or other traumatic event, the Medic once. Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Louise Consella Martin Weir 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) John J. Purcell Husband 8020 Glendale Drive Frederick, MD 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/3/2008 | East Dorsett , VT St. Jerome Cem 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney & Basford P.A. F.H. 106 East Church Street Frederick, MD 21701 M00176 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 3-4 Days. Dneumania Due to (or all a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (bisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy for Day in the past 12 months? 1 Yes 2 No 9 Unknown 4☐Pregnant at time of death 5 Other (specify) detached 9□Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown PU Imanon Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ₩ No 24a. Was an page 2 s autopsy performed? 1□ Yes 2 No director Be 26. Place of Death (Check only one)

Physician /Medical Examiner

requires that the death certificate be executed

certificate has

this

After

after death.

Director: /

To the Hospital o within 24 hours aft To the Funeral Di completely filled in

Hospital or Attending

Division or Vital Records, P.O. Box 68760,

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

5 Pending investigation

28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 Natural 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide

Hospital:

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year)

Shah N

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Certification: To

Medical

Thoma hanson MAR 3 1 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Mary		rtificate of I		, ,	Jiene leg. No. 🤈 🖺 🕦	8 10293
	Physici		1. Decedent's Name (First, Middle, Las Patricia	clementine	e Pr	octor		2. Date of Dea Month March 15		3. Time of Death 2:00 P M
Val.	/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	L	4c. County of D	eath
	<u> </u>	-1	Crescent Cities Center 5. Social Security Number 6. So	7 Ago (/r	a ven lant hirthday	Rive	erdale If Under 24 Hrs.	9 Date of Birth	Prince G	eorge's Birthplace (State or Foreign
	Funeral Director			=X	yrs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day August 1	5, 1947	Washington, DC
	yland now at		10a. State 10b. County		c. City, Town or Lo	ocation				10d. Inside City Limits
	ne Mar 8a-f sl otified	ector	Maryland Prince Ge	orge's	Capitol				10 000 1000	1 □ Yes 2 💆 🐪 o
	th with the 23a or 2 ust be no	Funeral Director	10e. Street and Number 5729 Eagle Street			10f. Zip Code 20743			log. Citizen of What USA	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.		11. Marital Status 1 □ Never Married 2 □ Married XXIVIdowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 KNo If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 (X) X) o	Specify:		14. Race - A Black, W Specify:	merican Indian, 'hite, etc. Black
Maryland 21215-0036	thin 72 hc e. an "natu Medical	Completed by	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)		dent's Usual Occup kind of work done of DO NOT use retired		king	16b. Kind of Busine Prince Geor	•
121	filed wil Hygien other th	Con	17. Father's Name (First, Middle, Last)		School	ol Bus Drive			Maiden Surname)	ge s County
lan	should be tind Mental Is marked o	To Be	James Proctor				Aline	Thomps	-	
Mar	1 and 2 sho Health and I tem 27 is ma other trauma		19a. Informant's Name/Relationship (T Delores Queen / Sis			ng Address <i>(Street :</i> Pagle Stre			r, City or Town, Stat Maryland	e, <i>Zip Code)</i> 20743
Baltimore,	Pages 1 and of Herant of Herant If Item		20a. Method of Disposition 1 ☑ Surial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification of the control	Removal from State	_	osition (Name of matory or other place on Cemeter	1	Date /2008	20c. Location - City	
Baltir	permit. F Departme Importan any injur		21. Signature of Cheral Service Dicerr		2	2. Name and Addres	ss of Facility	George P.	Kalas Funer	al Home P.A.
b			23a. Parti. Enter the disease, or com shook or heart failure. List only	olications that caused the						Approximate Interval Between
	Physician	8 6	Immediate Cause (Final disease or condition resulting in death)	BREAS	T CANCER					Onset and Death
	/Medical Examiner			Due to (or as a co	onsequence of):					
	ed sit	iner	Sequentially list conditions, if any, leading to immediate	Due to (or as a co	onsequence of):					
oʻ	ificate be executed g physician and as the burial-transit	Examiner	that initiated events resulting in death) Last	C Due to (or as a co	onsequence of):					
68760,	ficate be physici s the bu	edical		d						
P.O. Box (death cert e attending d for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant In the past 12 months? 1 □ Yes 2™ No 9 □ Unknown	23c. If yes, outcome pf p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	⊒Ectopic pregnancy ⊒ Other (spec <i>ify)</i>	y		23d. Date of Month	delivery Day Year
	The law requires that the dividence by the signed by the sage 2 should be detached	þ	Part II. Other significant conditions of Neuropathy	ontributing to death but n	ot resulting in the u	inderlying cause giv	en in Part I.		obacco use contribut 'es 2 No 3 □	e to the cause of death? Probably 4 Aunknown
000	aw req is beer 2 shou	Completed	Debility					24a. Was a	an 24b. Were	e autopsy findings available to completion of cause of
E E		Com	Anasarca					perfor 1□ Yes	rmed? deat	h? ∕es 2∐No
Vita	Physician: The this certificate had director, page	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	2 ☐ ER/Outpatie	nt 3□ DOA Oth	or:	th <i>(Check only o</i>	ne) lence 6 □Other (8	Specify)
n or	ing Phy After thi Ineral o		27. Manner of Death Yatural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	28b. Time of Injury	Wor	y at k?		now injury occurred	, ,,
Division or Vital Records,	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		At home, farm, st Specify)		Yes 2 ☐ No	28f. Location (S City or Tow	Street and Number o. vn, State)	r Rural Route Number,
_	To the Hospital within 24 hours a To the Funeral I completely filled	Medical Ce		ysician: To the best of m niner: On the basis of ex and manner stated	amination and/or in					
	To the within 2 To the comple	Mec	29b. Signature and title of dertifier	0 M.D		29c. Licens			29d. Date signed (M	
	(1)		> Suluna			D 0064	4208		March 17, 20	08
12			30. Name and address of person who Saadia Husain MD	completed cause of death 4409 Fast-West	Highway,	Riverdale, N	Maryland 2	0737		
	Sta	ite	31. Date filed (Month, Day, Year) MAR 1 8 2008	32. Registrar's	Signature ::	tu				

			For State	State	of Marylar					-	_	2000	10001
	_		State Registrar 1. Decedent's Name (First, Middle	e /ast)		Cel	rtificate o	Deat	n	2, Date of De	Reg. No.	2000	3. Time of Death
æ	Physici		Betty L. Prova							Month	Day		8.6
¥	/Medic Examin		4a. Facility Name (If not institution		ımber)		4b. City, Town	, or Locatio	n of Death	March		2008 County of Deat	5:25 p ™
			Berlin Nursing	and Reha	b Cente	r	Berli	n				Worcest	er
Playie	Funeral Director		5. Social Security Number 208-24-8271	6. Sex 1 ☐ M 2 🗶 F	7. Age (In yrs. 77	. last birthday) Yrs.	If Under 1 Yes		ler 24 Hrs. s Min.	8. Date of Bir (Month, Date 8/15/1	930	9. Birt	hplace (State or Foreign nuntry) PA
	and w		Usual Residence of Decedent 10a, State 10b, County		10c, C	ity, Town or Lo	cation						10d, Inside City Limits
	Marylis f sho	ro	,	cester		Berlin							1 □Yes 2 X No
,	r 28a	Funeral Director	10e. Street and Number	,03001		DCT TTI	10f. Zip Code)			10g. Citiz	zen of What Co	Juntry?
3	th with	al D	22 Briarcrest [)r.			21811				USA		
	r dea	ner	11. Marital Status	Armed F		J.S. 13.	Vas Decedento If Yes, specify C	f Hispanic (uban, Mexi	Origin? (Specan, Puerto	ecify Yes or No Rican, etc.))- 1	 Race - Ame Black, White 	
36	s affe ,'or if	by Fi	1 X Never Married 2 Mar 3 Widowed 4 Divorced	If Yes. G	2 💢 No live		1□Yes 2 <mark>X</mark> N	lo <i>Speci</i>	ify:			Specify: Wh	nite
ξ,	be flied within 72 hours after death with the Maryland tal Hygiene. And then 'natural', or items 23a or 28a-f show event, the Medical Examiner must be notified at	edk	15. Deceden	it's Education		16a. Dece	dent's Usual Occ	cupation			16b. Kir	nd of Business/	C = 1 = 1
215	hin 72 e. an "na Media	Completed	(Specify only highe Elementary/Secondary (0-12)	st grade completed, College	(1-4or 5+)	1	kind of work doi DO NOT use ret	ne during m ired)	ost of work	ing			
21	ed wit ygiene ygiene rer tha	Con			5+ ′	Te	acher	1 .				ucation	1
Maryland 21215-0036	tal H	Be	17. Father's Name (First, Middle, Theron Dale Pro	*					ther's Name h Han	e (First, Middle	, Maiden .	Surname)	
<u> </u>	ss 1 and 2 should be in the all works the strain and Mental item 27 is marked or other traumatic ever	2	19a. Informant's Name/Relations		 -	19b Mailir	ng Address (Stre				er City o	Town State	Zin Code)
	and 2 s ealth an n 27 is i ner trau	١.,	Shirley Findlay			1	riarcre				-		<u> </u>
ē,	of Hea	1 3	20a. Method of Disposition			Place of Dispo	sition (Name of			Date		cation - City or	Town, State
ׅ֟֝֟֝֟֝֟֝ 			1 ☐ Burial 2 🛣 Cremation 4 ☐ Donation 5 ☐ Other (5		State C		lopen C	,	3/18	/2008	Fra	nkford,	DE
Baltimore,	permit. Pag Department Important; It any injury o		21. Signature of Funeral Service	Licensee			Name and Add						Home
	<u> </u>		22 Part Finter the disease of	r complications that	caused the dea		08 Will					1011	Approximate
O F	Physician [*]	4	23a Part1. Enter the disease of shock, or heart failure. List Immediate Cause (Figure disease or condition	only one cause on	each line.	fic	Gastr	1 6 C	arci	10 Ma			Interval Between Onset and Death
	/Medical		resulting in death)	a. Due to	o (or as a conse	quence of):							(0)
B	Examiner		Sequentially list conditions,	b									
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Die	eenon is es-10) i	quence one							
6	al-trar	Exan	that initiated events resulting in death) Last	c	o (or as a conse	quence of):							
8760	death certificate be executed e attending physician and dor use as the burial-transit	dical E		d									
9		Medi	IC CCAAAL C.										
Box	ath cel tendir or use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1□Live	utcome pf pregr birth 2 ☐ Fet	tal death 3 🛭	∃Ectopic pregna				2	3d. Date of de Month	livery Day Year
0	at the death certifi by the attending p tached for use as	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Preg 9□Unk	gnant at time of nown	death 5	Other (specify,					WOTH	Day Tour
J	88		Part II. Other significant conditi	ons contributing to	death but not re	sulting in the u	nderlying cause	given in Pa	ırt I.	23e. Did	tobacco u	se contribute to	the cause of death?
ds,	w requires that the been signed by th should be detache	d by	Coronay	Anten	Dis	case				1 🗆	Yes 2	□No 3□P	robably Unknown
Record		lete		- /						24a. Was		24b. Were at	utopsy findings available
	sician: The law certificate has b irector, page 2 sl	Completed								auto perfe 1□ Yes	psy ormed? 2 No.	prior to death?	completion of cause of 2 □ No
Vital	stan: ertifica ctor, p	Be C	25. Was case referred to medica examiner?	1			<u>s.</u>		ace of Deat	h (Check only		1	
o .	Physic this ce	2	1 ☐ Yes 2 No			ER/Outpatier	IL 3 DOA		Nursing Ho			3 □Other (Spe	ecify)
uo !	ding F h. After funer	ion:	27. Manner of Death 1 Natural 5 Pendir 2 Accident investi	ng (Mo	e of Injury Inth, Day Year)	28b. Time o Injury		njuryat Vork? ∐Yes 2	□No	28d. Describe	now injur	y occurred	
Division	I or Attendi after death. Director: A	ficat	3 Suicide 6 Could	not be 28e. Plac	e of injury - At I	home, farm, sti							ural Route Number,
	tal or safter safter al Dire	Certification:	4 ☐ Homicide determ	build	ding, etc. (Spec	city)				City or To	wn, State,	,	10
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical (ng Physician: To the Examiner: On the and ma									
1	To th To th comp	Me	29b. Signature and title of certifie	7	_	1	29c. Lice	ense numbe	er	9		e signed (Mon	
)			1 TW	mus		1>	E	128	576	• (5	1071	08 De 19944
2	0 10		30 Name and address of person	who completed cau	use of death (Ite		Coastel	1L'	C	F	A 5	Felo. 1	De 1994U
BA	9 12 Sta	to	31. Date filed (Month, Day, Year,	32.	Registrar's Sigr		Walley	110	way	i Euw	4	June	000000
	Registr		MAD 1 8		Made a	H. A	certie		•				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2008 March 13 1310 PM Harry Edward Parsons /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 358 Ricketts Mill Road Ceci1 E1kton If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X** M 2□ F Yrs. May 10, Director 212-50-3785 60 1947 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County show "natural", or items 23a or 28a-f shov edical Examiner must be notified at 1 ☐ Yes 2 No Director Ceci1 Maryland E1kton 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 358 Ricketts Mill Road 21921 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Heating, Ventilation, Elementary/Secondary (0-12) College (1-4or 5+) and Air Conditioning Service Technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Parsons Iva Lee Biggs 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Parsons/Wife 358 Ricketts Mill Road, Elkton, MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) March 17 20c. Location - City or Town, State 20a. Method of Disposition 1 A Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Elkton Cemetery 2008 Elkton, MD 22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** acte myeard /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and burial-trans Due to (or as a consequence of): ed by the attending physician detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an 1□ Yes 2风 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 5 Residence 6 □Other (Specify) Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fu 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Division or Vital Records, P.O. Box 68760

State Registrar

31. Date filed (Mon

(Check only

29b. Signature and title of certifier MB

R 1 8 2008

29c. License number

29d. Date signed (Month, Day, Year)

mai St. Elicker Md 219)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

223 We HSU

MD

32. Pygistrar's Signature

			Please Type or Print in Black Inc State of Maryland / Depa		-	•	
		•	1 = State Registrar Cer	tificate of Death	Re	eg. No.2 () () 8	10296
	第 章	91	1. Decedent's Name (First, Middle, Last)		Date of Death Month	h Day Year	3. Time of Death
16	Physici /Medic		Dorothea Grace Plank-Pelphrey		March	12, 2008	6:21P M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
A STATE OF		184. 17	25936 Fox Grape Road	Greensboro		Caroli	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 🖾 F 75 Yrs.	Months Dave Hours Min	8. Date of Birth (Month, Day, April 7	Year) Cou	place (State or Foreign ntry) Land
	and www.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	cation			10d. Inside City Limits
	Mary f sho	힏	Maryland Caroline Greensbo	ro			1 ☐ Yes 2 No
	r 28a	Director	10e. Street and Number	10f. Zip Code	10	Dg. Citizen of What Cou	ntry?
	h with		25936 Fox Grape Road	21639		U.S.A	
	deat	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. V Armed Forces?	Vas Decedent of Hispanic Origin? (Spec f Yes, specify Cuban, Mexican, Puerto F	cify Yes or No-	14. Race - Ameri Black, White	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland that Hygliene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☒ No	☐ Yes 2🏋 No Specify:	iodit, otoly		nite
0	72 ho natur lical	ted	15. Decedent's Education 16a. Deced (Specify only highest grade completed) (Give	ent's Usual Occupation kind of work done during most of workin	· ·	16b. Kind of Business/Ir	ndustry
7	within iene. than " he Mec	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	OO NOT use retired)		.	
2	filed wi Hygier ther th	ပ်	12 4 nurs			private pra	actice
pu	be fil d oth even	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	, , , ,	,	
<u>X</u>	2 should be and Mental Is marked or raumatic eve	은	Herbert Atwood Plank			her Plank	
<u>a</u>	12 sh h and 7 Is m traum		1 17	g Address (Street and Number or Rura			*
a)	1 and Health			Fox Grape Road; G		ro, Marylai 20c. Location - City or T	
Š	ages 1 and 2 should bent of Health and Ment t: If Item 27 is marked y or other traumatic e			natory or other place)		•	
Baltimore,	it. Pertrant			ro Cemetery 03/20, Name and Address of Facility	2008	Greensboro,	, maryland
Ba	permit. Pages 'Department of HIMPortant: If Ite any injury or of once.		I Steph C Flegh PO	eegle and Helfenbe Box 160; Greensbo			•
			23a. a 11. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac of	respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition a Metastaw	Lune Cancel			5 years
	/Medical		resulting in death) Due to (or as a consequence of):	0			
	Examiner	L	Sequentially list conditions, b.	V			
	ed sit	ine	Sequentially list conditions, if any, footing to immediate cause. Enter Underlying Cause (Disease or injury				
	be executed ician and burial-transit	Examine	that initiated events resulting in death) Last C. Due to (or as a consequence of):				***************************************
9							
687	icate phys s the	혏	d				
Вох	that the death certificate be exited by the attending physician detached for use as the burial	Physician/Medical		Ectopic pregnancy Other (specify)		23d. Date of deliv	very Day Year
О	that ed by deta		Part II. Other significant conditions contributing to death but not resulting in the ur	derlying cause given in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
S _D	requires seen sign hould be	d by			1 □ Ye	es 2□No 3□Pro	bably 4. Unknown
or Vital Records,	w requires that been signed I should be det	Completed			24a. Was ar	24h Were aut	opsy findings available
Be	e fa has	E D			autops	y prior to co	ompletion of cause of
Ø	ician: Th certificate rector, pag	ပိ	25. Was case referred to medical	26. Place of Death		No 1 □ Yes	2□ No
>		To B	examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	Othor			ifiz)
ō	g Physer this eral di		27. Manner of Death 28a. Date of Injury 28b. Time of			w injury occurred	(9)
Division	Attending r death. ector: After by the fune	Certification:	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
S	Atter	ifica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street building, etc. (Specify)	eet, factory, office 2		reet and Number or Rui	ral Route Number,
	al or s afte	F	Full ling, etc. (Specify)		City or Town	, State)	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death and manner stated. Certifying Physician: To the best of my knowledge, death and manner stated.				
	To the within 2 To the comple	Me	29b. Signature and title of certifier	29c. License number	25	9d. Date signed (Month	, Day, Year)
				D0053815		3/14/2	008
,			39. Name and address of person who completed cause of death (Item 23a) (Type,	Print)			-
	_		Korah Pulimood, MD 510 S. 5th Stree	t; Denton, MD 2162	29		
h	≫ Sta	ite	31. Date filed (Month, Day, Year) AAR 1 9 2008 32 Registrar's Signature	a ill a			
	Registr	rar	WAST 2 2 5000				
DH	MH 17 Rev 1/2	001					

			For State of Ma		artment of Health rtificate of Deat	h	Reg. No.	18 10297
	Physicia		1. Decedent's Name (First, Middle, Last) JAMES KILROY QUEEN, SR.			2. Date of D MARCH	Pay, 200	3. Time of Death 8:30 P M
	/Medic Examin	al er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Locatio	n of Death	4c. County of I	
	····		RESIDENCE. 2350 MAIL COACH C	OURT (In yrs. last birthday)	WALDORF If Under 1 Year If Und	er 24 Hrs. 8. Date of B	CHARL irth 9.	ES Birthplace (State or Foreign
Ŀ	Funeral Director		214-58-4829 1 ¹ X M 2□ F	55 Yrs.	Months Days Hours	Min. JULY	8, 1952 M	ARYLAND
	and w t		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
	e Mary a-f sho ified a	ctor	MARYLAND CHARLES	WALDORF				1 X Yes 2 No
	with the	Director	10e. Street and Number 2350 MAIL COACH COURT		10f. Zip Code 20602		10g. Citizen of Wha	•
	death	Funeral	11. Marital Status 12. Was Decedent E Armed Forces?	ever in U.S. 13.	Was Decedent of Hispanic of Hispanic of Yes, specify Cuban, Mexic	Origin? (Specify Yes or N		American Indian,
36	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	by Fu	1 Never Married 2 Married 1 Yes, Give 3 Widowed 4 Divorced Year or Dates:	lo	1 ☐ Yes 2 No Speci		Specify:	White, etc. BLACK
21215-0036	2 hour latural	ted b	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation	agent of working	16b. Kind of Busin	- 1132233
121	within 7 iene. than "r he Med	Completed	Elementary/Secondary (0-12) College (1-4or 5-		e kind of work done during m DO NOT use retired) ABORER	iost of working	CONSTR	UCTTON
	il Hygie other t ent, th	Be Co	17. Father's Name (First, Middle, Last)		18. Mo	ther's Name (First, Middl	e, Maiden Surname)	
ylan	should be ind Mental marked o	To B	JOSEPH SYLVESTER QUEEN			CE ELLA MAE	<u>_</u>	
Maryland	is all		19a. Informant's Name/Relationship (Type. Print) WENDY QUEEN / WIFE		ing Address (Street and Nun MAIL COACH C		-	
	es 1 and 3 of Health fitem 27 r other tr		20a. Method of Disposition 1	20b. Place of Dispo		Date	20c. Location - City	
Baltimore,			4 □ Donation 5 □ Other (Specify)			MARCH 21,2008		MARYLAND
Bal	permit. Pag Department Important: I any injury o	0) 3		N ROAD, IND	IAN HEAD,	MARYLAND 20640
			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	the death. Do not en e.				Approximate Interval Between Onset and Death
6	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a condition resulting in death)	a consequence of):	Colon	(ances		4 years
	Examiner		Sequentially list conditions, b.					
	uted Insit	Examine	cause. Enter Underlying Cause (Disease or injury	a consequence of):				
Ö,	tificate be executed Ig physician and as the burial-transit		that initiated events resulting in death) Last C. Due to (or as a	a consequence of):				
68760,	cate be physici	edical	d					
Box (eath certifi attending for use as	In/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome		□Ectopic pregnancy	75 - 10	23d. Date o	of delivery
	law requires that the death cert as been signed by the attending 2 should be detached for use a	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 1 □ Ves 2 □ No 9 □ Unknown		Other (specify)		Month	Day Year
, P.O	w requires that the dibeen signed by the should be detached		Part II. Other significant conditions contributing to death but	ut not resulting in the u	underlying cause given in Pa	urt I. 23e. Dio	I tobacco use contribu	ute to the cause of death?
ords	equires en sigi ould be	ted by				1]Yes 2□No 3[☐ Probably 4 Unknown
360	e law r has be je 2 sh	Completed				24a. Wa	s an 24b. Wer topsy prio formed? dea	re autopsy findings available or to completion of cause of oth?
tal	sician: The certificate ha rector, page		25. Was case referred to medical		26. Pla	1□ Yes ace of Death (Check only	2 X No 1□	Yes 2□No
or Vital Records,	Physician: this certific ral director,	To Be		nt 2 ☐ ER/Outpatie	ent 3 DOA Other: 4	Nursing Home 5X Re	sidence 6 □Other	(Specify)
	ding J. After funel	tion:	27. Manner of Death 1	Year) 28b. Time of Injury	of 28c. Injury at Work? M 1 ☐ Yes 2		e how injury occurred	
Division	Attending or death. rector: After by the funer	Certification:	2 Accident	ıry - At home, farm, st c. (Specify)		28f. Location	(Street and Number o	or Rural Route Number,
ō	Hospital or .24 hours after Funeral Directel filled in the				the account of the time date			
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) 1	examination and/or in				
	To the within 2 To the comple	Ň	29b. Signature and title of certifier	417	29c. License numbe	er (/	29d. Date signed (/	
			30. Name and address of person yno completed cause of de	eath (Item 23a) (Tyne	Print) 1962	276	MARCH 18,	, 2008
	005		M.A. MEE	Lu	Waldor	MD	20603	
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registre	ar's Signature	Posele			

			For State		State	of Maryla	and / Depa	artment			and Me				
- 40		-	Registrar 1. Decedent's Name (Firs	t Middle La	et)	-	Cei	uncate	e oi L	Jeam		2. Date of Dea	leg. No.	008	3. Time of Death
	Physici	an	Isadore Lo									Month	Day	Year	
i grad	/Medic		4a. Facility Name (If not in			ımher)	-	4b. City.	Town, or	Location of	of Death	March		008 ounty of Death	11:50 A.M
	Examin	er	Carriage Hi	_				Beth			. = 0			Iontgome	erv
	Funeral		5. Social Security Number	r 6. 5	Sex	7. Age (In y	rs. last birthday)	If Under	1 Year	If Under		8. Date of Birth (Month, Day	1		lace (State or Foreign
	Director	Ì	284-40-7291		I ∑ M 2□ F	9	5 Yrs.	Months	Days	Hours	Min.	Jan. 4			ylvania
	pui w		Usual Residence of Dece 10a. State 10b.	dent County		100	City, Town or Lo	cation						1	0d. Inside City Limits
	faryla sho ed at	5		ntgome	erv		Bethesda								1y⊈Yes 2 □ No
	the A 28a-1 notifi	Director	10e. Street and Number	3	1			10f. Zip	Code			1	10a. Citize	n of What Cour	try?
	4 within 72 hours after death with the Maryland jiene. r than "natural", or items 23a or 28a-f show the Medical Exeminer must be notified at		6703 Loring	Court	t				2081	7				ed Stat	•
	ms 2	Funeral	11. Marital Status		12. Was Dec	cedent Ever in	u.S. 13.	Was Deced If Yes, spec	dent of Hi	spanic Ori	gin? (Spec	cify Yes or No-	14	. Race - Americ	
9	after or ite mine		1 ☐ Never Married 2	Married		2 No		n res,spec 1⊡ Yes 2	-	Specify:		ilicair, etc.)		Black, White,	
21215-0036	iral",	d by	3 ☐ Widowed 4 ☐ □	ivorced	Year or I	Dates: WW	11			. ,				^{Specify:} Whi	
5	"natı	Completed	15. E (Specify on	ecedent's E ly highest gra	ducation ade completed)	16a. Dece	dent's Usua kind of wor DO NOT us	al Occupa rk done c se retired	ation <i>Juring mos</i>	t of workin	9	16b. Kind	d of Business/Inc	dustry
7	withir ene. than he M	ğ	Elementary/Secondary	(0-12)	College	(1-4or 5+)		il Ser					II.S	. Gover	nment
	file Hyg sht,		17. Father's Name (First,	Middle, Last	-		CIV	ri per	Lvaiit		er's Name	(First, Middle,			IIICIIC
Maryland	should be nd Mental marked c matic eve	To Be	Charles Ri	.sen						Ros	e Lo	ondon			
ary	0)	_	19a. Informant's Name/R	elationship (Type. Print)		19b. Maili	ng Address	(Street a	and Numbe	er or Rura	Route Numbe	r, City or T	Town, State, Zip	Code)
	is 1 and 2 of Health a item 27 is other trai		Barbara J.	Gotts	chalk/D	aughter	2101	Conne	ecti	cut A	ve. I	N.W. Wa	-	 	.C. 20008
ore	0 0		20a. Method of Dispositio 1 ☐ Burial 2 ☐ Cre		Removal from		b. Place of Dispo cemetery, cre	matory or ol	ther plac	<i>ө)</i> М	$\operatorname{arch}^{^{\scriptscriptstyle{\mathrm{D}}}}$	8		ation - City or To	·
ij	. Pages tment of I tant: If ite jury or o		4☑Donation 5□	Other (Special	fy)	117	eo. Wash edical (enter	^		2008	1000		ngton,	
Baltimore,	permit. Pag Department Important: any injury conce.		2) Signatur of Funeral	Service Lice) c									-	ices,P.A.
	40760	\vdash	23a. Part1. Enter the dis	0000 01 000	stight that	aquand the d						Lanhar		20706	Approximate
			shock, or heart failu Immediate Cause (Final	re. List only	one cause on	each line.	eatii. Do not en	er the mode	e or ayırı	y, suomas	cardiac of	respiratory an	1631,		Approximate Interval Between Onset and Death
ì.	Physician /Medical		disease or condition resulting in death)	-		monia	sequence of):							1	Day
	Examiner				Due to	(or as a cons	sequence on.								
3.	S DUN	Jer	Sequentially list condition if any, leading to immedia	ns, ate	b. Due to	(or as a cons	sequence of):								
	cuted nd ransit	Examiner	if any, leading to immedia cause. Enter Underlying that initiated events	1	C										
Ő,	be executed sician and burial-transit		resulting in death) Last		Due to	o (or as a cons	sequence of):								
8760,	the the	dical			_d										
9	The law requires that the death certific tte has been signed by the attending p tage 2 should be detached for use as	/Me	IF FEMALE:		23c. If yes, or	stcome of pre	anancy								
Вох	eath c attender for us	Physician/Me	23b. Was decedent preg in the past 12 month		1 ☐ Live	birth 2 F	etal death 3	Ectopic pro					23	d. Date of delive Month	ery Day Year
P.O.	the d	iysid	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9□Unk		or doddin - OL	_ Other (4p)							
σ.	ires that the de signed by the a be detached		Part II. Other significant	conditions	contributing to	death but not	resulting in the u	nderlying ca	ause give	en in Part I		23e. Did to	bacco use	e contribute to t	ne cause of death?
rds	quires n sign ald be	d by	Dementia Ad	lvance	d, Card	iomyop	athy					1 🗆 Y	es 2	No 3□ Prob	pably 4 □Unknown
or Vital Records,	aw requir s been si 2 should l	Completed	Coronary Ar	tery I	Disease	:						24a. Was a		24b. Were auto	psy findings available
Ä	The lavate has	mo	Hypertensic	าก								autop perfor 1□ Yes	med? 2 X No	death?	mpletion of cause of 2□ No
ita	sician: The certificate rector, pag	Be C	25. Was case referred to examiner?						.0	26. Place	of Death	(Check only o			
<u>></u>	iys dir	To	1 ☐ Yes 2 🔀 No				2 ☐ ER/Outpatie			7 (304) 10	rsing Hon	ne 5 🗆 Resid	lence 6	Other (Specif	y)
u u	Ing Ph		27. Manner of Death 1 XNatural 5]Pending		e of Injury nth, Day Yea	r) 28b. Time o		8c. Injun Work			8d. Describe h	ow injury	occurred	
Sic	Attending F r death. ector: After by the funera	cati	2 ☐ Accident 3 ☐ Suicide 6 ☐	investigatio Could not b	e las Blac	o of injun.	at home, farm, st	M factors		Yes 2□		196 Location /6	Street and	Number or Dun	al Route Number,
Division	or A after of Direction by	Certification:	4 ☐ Homicide	determined	build	ding, etc. (Sp	ecify)	eet, lactory	, once		-	City or Tou	n, State)	Ivaniber or nare	a noute trainbei,
_	To the Hospital or Atte within 24 hours after des To the Funeral Directo completely filled in by th	S S					knowledge, deat								
	n 24 h	edical			miner: On the		nination and/or in								
	To the within To the Comp	Me	29b. Signature and title of		٦٠	10				number			_	signed (Month,	
			1 KrtV	yar	non	NW		1	05336	<i>31</i>			March	14,200	0
	20		30. Name and address of	-	•		Item 23a) (Type,	Print) C	2801	Geor	gia <i>I</i>	Avenue MD 209	Suite	117	
			Rajan Sh			D. Registrar's Si	anaturo		Silve	er Sp	ring,	MD 209	02		
	Sta Registi		31. Date filed (Month, Da MAR	1 7 20	08	negistrar's Si	-	ut)							

DHMH 17 Rev 1/2001

State

Registrar

Sirak Lemma, MD

MAR 1 8 2008

31. Date filed (Month, Day, Year)

1500 Forrest Glen Road Silver Spring, MD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			ForState	State	of Maryla		rtment of				0.0	000	1.25	000
			Registrar	- 1 4)		Cer	tificate of	Death	1	2. Date of Dea	Reg. No.	ЩВ	3. Time o	3 U U
	Physicia	an	Decedent's Name (First, Middle	a, Last)					1	Month	Day	Year		r Death M
	/Medic		LAWRENCE	RIZER	umbor)	1	4b. City, Town	or Location	of Death	03	4c. Count	2008	0625	_A
1	Examin	er	4a. Facility Name (If not institution		uniber)				OI Death					
	Funeral		WMHS MEMORIAL 5. Social Security Number	6. Sex	7. Age (In yrs	s. last birthday)	CUMBERI If Under 1 Year	r If Unde	r 24 Hrs.	8. Date of Birth	ALLE	0 70 11	olace (State	or Foreign
	Funeral Director		214-07-3702	1 ∑ M 2□ F	8	9 Yrs.	Months Day	s Hours	Min.	(Month, Day	v, Year) er 06, 1918	Coui	Maryl	and
3			Usual Residence of Decedent											
	arylar show	_	10a. State 10b. County		10c. C	City, Town or Lo	cation					1	10d. Inside C	ity Limits 2 □ No
	8a-f s	cto	Maryland	Allegany					Savage					
3	within 72 hours after death with the Maryland ene. Than 'matural', or Items 23a or 28a-f show he Medi-al Examiner must be notified at	Funeral Director	10e. Street and Number				10f. Zip Code				10g. Citizen of		-	
ŧ	sath v s 23a nust	eral		17 Foundry R	cedent Ever in	116 112 3	Non Dependent of		1545	oify Vos or No	14 Ra	ce - Americ	S.A.	
_	ter de Item ner r	in in	11. Marital Status 1 ☐ Never Married 2 ☒ Married	Armed I	Forces?	0.3.	Was Decedent of f Yes, specify Co	ıban, Mexica	an, Puerto	Rican, etc.)	Bla	ck, White,		
0030	irs af il'; or xami	by	3 ☐ Widowed 4 ☐ Divorced	If Yes. 0	Give _		1□Yes 2XN	o Specify	<i>/</i> :		Speci	fy:	Wh	ite
٢ ,	2 hou			nt's Education	-0	16a. Deced	dent's Usual Occ	upation	at of works		16b. Kind of E	Business/In	dustry	
2 2	hin 7	ble	(Specify only higher Elementary/Secondary (0-12)		(1-4or 5+)	life.	kind of work dor OO NOT use reti	red)	ist of Worki	ng				
7	ed wif	Completed	8		0			Man					pground	
and	be filed within 72 hours after death with the Marylar Hydjene. 4d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Be (17. Father's Name (First, Middle,	*				18. Moth	ner's Name	(First, Middle,		,		
<u>ya</u>	ould be Menta larked latic ev	ို			ge Rizer			<u> </u>			Lena Faul			
Mar	2 sh n and is m raum		19a. Informant's Name/Relations		ic.	19b. Mailir	ng Address (Stre				•			
ر رو	l and lealth im 27 ther t	1 3	20a. Method of Disposition	ae Rizer - W		Place of Dispo	1391 / sition (Name of	Foundr	-	NW, Mt. S	20c. Location			
0	Pages ' nent of h int; If ite iry or of	0.4	1 ☐ Burial 2 ☐ Cremation		I .	cemetery, crei	natory or other p			March 21,		,	e, Maryl	and
altimor	it. Pa ritmer ritant njury		4 ☐ Donation 5 ☐ Other (5			-	ap Veteran	i	•	2008			•	and
g	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic evonce.	. 1	` /	mil.		-	2. Name and Add	Eichi East Ma	iorn-M	cKenzie Fi et, Lonaco	uneral Hor	me P.A		
г			23a. Part 1. Enter the disease, o	r complications tha	it caused the de	eath. Do not ent						yland, 2	Approxima Interval Be	ite
	Physician	2. 7	Immediate Cause (Final	t only one cause or	n each line.								Onset and	Death
J	Physician /Medical		disease or condition resulting in death)		T FOOT to (or as a cons	GANGREN equence of):	1E					-		
	Examiner				,									
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter the manying Cause (Disease or injury that initiated events	Due 1	to (or as a cons	equence of):								
	ecuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c										
Ď,	The law requires that the death certificate be executed to has been signed by the attending physician and hage 2 should be detached for use as the burial-transit		resulting in death, Last	Due t	to (or as a cons	equence of):								
09/8	cate by	dical		d										
9 ×	ertific ding p	Me	IF FEMALE:	23c If yes	outcome pf pred	nancy				1729-	004 5	ate of deli-		
ROX	at the death certifi by the attending packed for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐Liv	e birth 2 Fe	etal death 3[☐Ectopic pregna ☐ Other (specify					ate of deliv Nonth	Day	Year
o.	the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Un										
<u> </u>	that led by deta		Part II. Other significant condit	ions contributing to	death but not r	resulting in the u	nderlying cause	given in Par	t 1.	23e. Did t	obacco use co	ntribute to	the cause of	death?
Records,	quires t	d by	SEVERE DEMENTI	A, ARI U	ΓI					1 🗆	Yes 2 No	3☐ Pro	bably 4]Unknown
ဂ	w require been sig should b	Completed								24a. Was	an 24b	. Were aut	topsy finding	s available
2	he la e has age 2	E C			-						psy ormed? 2 No	death?	ompletion of 2 ☐ No	cause of
			25. Was case referred to medic	al			525	26. Pla	ce of Deat	1 Yes th (Check only o		1 🗆 162	2 140	
5	ysicia is cer direct	To Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	! ☐ ER/Outpatie	nt 3 DOA	Other: 4 🗆 I	Nursing Ho	ome 5 ☐ Resi	dence 6 🗆 C	ther (Spec	eify)	
0	ig Phys ter this neral dii		27. Manner of Death	/8.4	ate of Injury fonth, Day Year	28b. Time o	of 28c. [njury at Vork?			how injury occ			
Ö	Attending F death. ctor: After y the funer	atio	L L / toordorit	tigation		, .,,		☐Yes 2[□No					
Division or	r Atte er de irecte	Certification:	3 Suicide 6 Could 4 Homicide deten	mined 200. Pic	ace of injury - A	t home, farm, st ecify)	reet, factory, offi	ce		28f. Location (City or To	Street and Nur wn, State)	nber or Ru	ral Route No	ımber,
	ittal c urs aff ral D												4-44	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical		ing Physician: To al Examiner: On the	e basis of exam									e(s)
	o the ithin 2 o the mple	Med	29b. Signature and tile of certifi		nanner stated.		29c. Lic	ense numbe	·r		29d. Date sign	ned (Month	n, Day, Year)
	¥¥ ¥ 8		1 9											
		۱	30. Name and address of perso	n who completed o	ause of death /!	Item 23a) (Type		54167			03 1	9 2	008	
	54	MA	Moshin Gaice	· M.			Avenue	Cunh	erlan	d, Man	land	2150	12	
		240	31. Date filed (Month, Day, Yea		2. Registrar's Si	gnature	10-1100/	0	J /-(- 1	1, 11	1 1 1	V120	1	

DHMH 17 Rev 1/2001

Registrar

MAR 2 1

200

			Please	Type or Print in State of Maryla					_	ible.	
			For State Registrar	State of Maryla		ertificate of			leg. No. 2	308	10301
330	Physici		Decedent's Name (First, Middle, Las MYRON REYNOLDS	t)				2. Date of Dea	Day	Year 2008	3. Time of Death
)	Examin		4a. Facility Name (If not institution, give	•			r Location of Death	1		ty of Death	1
, 10 m	Funeral		WMHS MEMORIAL CA 5. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 6. Social Security Number 8	7. Age (In y	rs. last birthda	Months Days		8. Date of Birth	1	9. Birth	nplace (State or Foreign
4	Director		220-10-7674 Usual Residence of Decedent	x ^{M 2□ F} 92	Yrs.			Jan. 4	1916	Mary	yland
aryland	show	_	10a. State 10b. County MD. Allega:		City, Town or Wester						10d. Inside City Limits 1€XYes 2 □ No
with the Ma	a or 28a-f	Director	10e. Street and Number 129 Wood St			10f. Zip Code 21 5	62		10g. Citizen of Unit e		Intry?
U36 urs after death	and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ₩ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 U.S. 1	3. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2X No		pecify Yes or No- o Rican, etc.)	14. Ra Ble Spec	eck, White	ican Indian, , etc. vhite
5-C	"natura dical E	eted	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Dec	cedent's Usual Occup we kind of work done b. DO NOT use retire	pation during most of wor	king	16b. Kind of I		
21215-0036 d within 72 hours af	r than the Me	Completed	Elementary/Secondary (0-12) unknown	College (1-4or 5+)		Electricia:			Plate	Glass	s Manufactur
Maryland 7 d 2 should be filed	d c eve	To Be C	17. Father's Name (First, Middle, Lest) Zachariah	r. Reynolds				ne (First, Middle, Belle N		ame)	
Mary	f Health and Men Item 27 Is marke other traumatic		19a. Informant's Name/Relationship (1			ailing Address (Street Wood St.					
Baltimore, bermit. Pages 1 a	Department of Health a Important; if Item 27 is eny injury or other tra		20a. Method of Disposition ↑ Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	cemetery, c	position (Name of rematory or other pla Cemetery	ce) 03/ 200	Date / 26/	20c. Locetion Wester		Town, State Maryland
Balt permit.	Departr Importa eny Inji		21. Signature of Funeral Service Licent	e Bal		22. Name and Addre					d 21562
E:	ysician and wall-transit he burial-transit	ical Examiner	23a. Part1. Enter the disease, or companion, which cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in	b. Due to (or as a cons	sequence of): sequence of): mer f	y Andr	+ ·				Interval Between Onset and Death
.O. BOX the death cert	y the attending physicia ached for use as the bu	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown	etal death	3 ⊟Ectopic pregnanc 5	у			Date of deli	very Day Year
rdS, P	been signed by the s	þ	Part II. Other significent conditions of		resulting in the	e underlying cause giv	ven in Part I.				the cause of death?
	cate has bee page 2 shou	Completed	CVA: HTW emerge	neg.				24a. Was a autop perfor	med?	o. Were au prior to d death? 1 ∐ Yes	topsy findings available ompletion of cause of
Or VITAL Physiclan:	s certificate irector, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 XInpatient 2	□ FR/Outnat	ient 3 DOA Oth	oor:	ath <i>(Check only of</i> Iome 5 ☐ Resid		ther /Cree	3.6.1
n Or ng Phy	th. :: After this certifica :: funeral director, p		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year	28b. Time	of 28c. Inju		28d. Describe h			аку)
UIVISION I or Attending	within 24 hours after death. To the Funeral Director: After t completely filled in by the funera	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		t home, farm,		Yes 2□No	28f. Location (S City or Tow		nber or Ru	rel Route Number,
L Hospital	24 hours a Funeral I	Medical Ce	29a. Certifier (Check only one)	ysician: To the best of my niner: On the basis of exam and manner stated.	knowledge, de nination and/or	eath occurred at the trining investigation, in my	ime, date and place opinion, death occu	e, and due to the curred at the time,	cause(s) and r	manner es e, end due	stated. to the cause(s)
To the	within To the compl	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date sign	ned (Montl	n, Day, Year)
)			· W				101 0101		03-	19-	2008
		10	Dr. Abdul Cheema	ompleted ceuse of death (I , 900 Seton D	rem 23a) (Typ Prive,	Cumberland	d, MD. 2	1502			
7	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 0	32. Registrar's Si		Specker					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. L. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** LYLE ROBERT SMITH MARCH 25, 2008 1:35P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ★M 2 ☐ F Director MD 216-38-0456 8-9-1940 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2X No Director MDFrederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a or Examiner must be r 21703 USA 5949 Elmer Derr Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ite, any injury or other traumatic event, the Medical Examiner 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Specify Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Brick & Block Mason East ALCO 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thelma Irene Rutherford ဥ Lyle F. Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5949 Elmer Derr Rd Frederick, MD 21703 Wife Bertha Smith 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Mem Grdn 3-29-2008 Frederick, MD 22. Name and Address of Facility Keeney & Basford P.A. F MO1176 106 East Church St Frederick MD 21701 21. Signature of Funeral Service Licerisee Allen 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician int-orpulmonn /Medical Due to (or as a consequence of): Examiner whowne Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed hoonig Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 2 No 1@Inpatient 2 ER/Outpatient 3 DOA မ this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 ☐ Pending investigation 15 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director; 6 ☐ Could not be 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral I 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 2-105CG MD 31. Date filed (Month, Day, Year) MAR 3 1 2008 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- For State Amend 23a &PII perME, g879 5/15/08 TT Certificate of Death

Red. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Morton SLEISINGER 4:00 P M 12, 2008 March /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Upper Marlboro 8106 Croom Station Road Year If Under 24 Hrs. 8. Date of Birth
Days Hours Min. (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days Months 1 XM 2 ☐ F West Virginia Yrs Sept. 23, Director 236-42-9824 78 Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits 10a State 10h. County at 1 ☐ Yes 2 No r 28a-f sh notified Prince Georges Upper Marlboro Director Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number o pe filed within 72 hours after death with 20772 ns 23a c must b 8106 Croom Station Road United States Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, iral", or items ? Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ No If Yes, Give 11. Marital Status Black, White, etc. white 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Specify. 3□Widowed 4□Divorced Year or Dates: WW – II "natural", 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If Item 27 Is marked other than iry or other traumatic event, the M Sidina Business 12 Salesperson 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rachel Abramovitz Saul Sleisinger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
19c. New York, NY 10022 Apt. 16L 19a. Informant's Name/Relationship (Type. Print) 25 Sutton Place South, New York, NY Marcia Silverblatt, Sister Department of Health Important: If Item 27 any Injury or other tr 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 03/20708 IM Burial 2 □ Cremation 3 □ Removal from State Cheltenham, MD Maryland Veterans Cemetery 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Servan License 22. Name and Address of Facility
Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC
23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Hypertensive atherosclerotic cardiovascular disease 20012 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** -Arteriosclerotic Hypertensive Heart Disease /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Year in the past 12 months? Day 4□Pregnant at time of death 5 ☐ Other (specify) 1 □ Yes 2 □ No 9□Unknown 9 ☐ Unknown signed by 1 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Diabetes mellitus 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No has certificate 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? 1 ✓ Yes 2 ☐ No Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA 1 🔲 Inpatient P this 27. Mann of Death To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? Certification: (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

or Vital Records, Division

Maryland 21215-0036

Saltimore,

Box 68760

P.0

MA

State Registrar 31. Date filed (Month, Day, Year) 17 2008

29b. Signature and title of certifier

(Check only one)

Registrar's Signature

3001

complet cause of death (Item 23a) (Type, Print)

0

ORIGINAL

2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Registrar

			S 1 - State Registrar	tate of Maryland / [) Оера		ealth and I	Mental Hyg	•	8 10305
	G		Decedent's Name (First, Middle, Last)					2. Date of Deat	:h	3. Time of Death
	Physici		YOUNG HWA	SEO				Month	Day Y	g llA M
	/Medic Examir		4a. Facility Name (If not institution, give stree			4b. City, Town, or	Location of Death	⊥MARCH_	4c. County of	
			RANDOLPH HILL NU	JRSING HOME		WHEATO	N		MONTG	OMERY
	Funeral Director		5. Social Security Number 6. Sex 1 M	7. Age (In yrs. last bir 95	thday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth OCT 120	^{Yea} 1912	Birthplace (State or Foreign Country) S KOREA
	pu ,		Usual Residence of Decedent	140- 01 T						
	72 hours after death with the Maryland netural', or Items 23a or 28e-1 show dical Examiliad at	Director	MD 10b. County MONTGOMER	RY SILV			NG			10d. Inside City Limits 1 X Yes 2 □ No
	with th	Dire	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wh	,
	s 23e	ral	1213 DOWNS DRIVE		10.1	2090		7.1		REA
9	after de or Item	Funeral	1 □ Never Married 2 □ Married	Was Decedent Ever in U.S. Armed Forces? I □Yes 211 No If Yes, Give		Vas Decedent of Hi f Yes, specify Cuba		o Rican, etc.)	Black,	American Indian, White, etc.
003	hours ural',	d by	3 Midowed 4 Divorced	Year or Dates:		Yes 2¶ No	Specify:			ASIAN
21215-0036	ne "ne	Completed	15. Decedent's Education (Specify only highest grade co.	mpleted)	(Give	lent's Usual Occupa kind of work done o DO NOT use retired	ation <i>during</i> most of wor)	king	16b. Kind of Busi	ness/industry
212	ted within ygiene. her then "	Com	Elementary/Secondary (0-12)	College (1-4or 5+)	HOU	SE WIFE			PRIVAT	E
	be filed ntal Hygi od other event, I	Be (17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle, I	Maiden Sumame)	
yla	should the marked remarked remarked	2	CHANG IK JUN				BOOK	WON N	(O	
Maryland	ges 1 and 2 should it of Health and Mer If item 27 le marke or other treumetic		19a. Informant's Name/Relationship (Type, EUN SOOK KIM /I			g Address (Street a			*	ate, <i>Zip C</i> ode) MD 20904
	s 1 and if Healt item 2 other		20a. Method of Disposition	20b. Place of	Dispos	sition (Name of	1		20c. Location - Ci	
nor	Pages nent of I snt: If its ury or o		1 Burial 2 ☐ Cremation 3 ☐ Remo '4 ☐ Donation 5 ☐ Other (Specify)	oval from State cemeter	ry, cren	natory`or other plac MEMORIA			OLNEY I	
Baltimore,	글 본 분 급 .		21. Signature of Fune al Service Licensee	A	-					UNERAL SERV
ñ	Depa Impo eny i		C All Vine	eks	4					MD 20772
	a		23a. Part F. Enter the disease, or complication shock, or heart failure. List only one call the complete Company (Figure 1)	ons that caused the death. Do rause on each line.	not ente	er the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	RESPIRATORY Due to (or as a consequence		AILURE				
ľ	Examiner		Sequentially list conditions b. —	HYPOXIA	oi).					
	D ≃	ner	Sequentially list conditions, if any, leading to immediate cause. Little funderlying Cause (Disease or injury that initiated events c	Due to (or as a consequence	of):					
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	of):					
760,	ite be ex iysician he burial	calE		Dua to (or as a consequence	OI).					
687	9 × e		d							
Вох	death certifica e attending ph d for use as th	In/M		f yes, outcome of pregnancy	2	T-4:-			23d. Date	of delivery
O. B	0 00 0	Physiclan/Med	1 Vos 2 Min	1□Live birth 2□Fetal death 4□Pregnant at time of death 9□Unknown		Ectopic pregnancy Other (specify)		·	Month	n Day Year
Δ.	that the		Part II. Other significant conditions contribu	uting to death but not resulting in	n the un	nderlying cause give	en in Part I	23e. Did tot	pacco use contrib	ute to the cause of death?
Records,	The law requires that the site has been signed by the page 2 should be detache	d by	CONGESTIVE HEAR			iconying access give		1		☐ Probably 4 【Winknown
CO	aw requir s been s s should	Completed	DEMENTIA					24a. Wasa		ere autopsy findings available
Re	The law cate has I	mo	20023221 10 20 2 3					autops perform	ned? dea	or to completion of cause of ath? Yes 2 No
Vital		Be C	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only on		
of <	S S S	To	1 ☐ Yes 2 ☐ No Hosp	1 ☐ Inpatient 2 ☐ EH/Ou		t 3□ DOA Othe	9r: 4X Nursing H	ome 5 Reside	nce 6 Other	(Specify)
o uc	ding Ph h. After th funeral	lon:	1 X Natural 5 ☐ Pending		Time of njury	28c. Injury Work	?	28d. Describe ho	w injury occurred	
Division	Attending r death. sctor: After by the funer	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	8e. Place of Injury - At home, fa	ırm. stre		/es 2□No	28f. Location (St.	reet and Number	or Rural Route Number,
Ö	el or / s after al Dire	Certification:	4 Homicide	building, etc. (Specify)	,	, , , , , , , , , , , , , , , , , , , ,		City or Town		
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	edical ((Check only 2 Medical Examiner:	n: To the best of my knowledge On the basis of examination an and manner stated.	death dor inv	occurred at the time restigation, in my op	e, date and place pinion, death occu	, and due to the ca rred at the time, da	ause(s) and mannate and place, and	ner as stated. d due to the cause(s)
	To the within 2. To the complet	Me	29b. Signature and title of certifier	1 1		29c. License	number	2	9d. Date signed (Month, Day, Year)
)			I Wan R.	fegal s	y	D5226	51		3/16/0	0.8
	(2)		30. Name and address of person who complete the second of	eted cau ie of eath (Item 23a)	(Туре, Г	29c. License D5 22 (1, 5	h/.	0 206	906
	Sta	te.	31. Date filed (Month, Day Jear)	32. Registrar's Signature	111	CIE 211	ver opr	ing, inc	(201	
•	Registr	100	MAR 1 8 2008	K Louis	15					

Divisi	To the Hospital or Atter	within 24 hours after deal	To the Funeral Director	completely filled in by the	
CR		(3)	
	×	F	Re	gi	

		State o	f Maryland.				nd Mental H		000	0	1000	40
		Registrar Registrar		Cer	tificate of L	Jeath		Reg. No.	200	Ö	1030	0
icia	n	1. Decedent's Name (First, Middle, Last)					2. Date of Month	Day		ear 3	Time of Death	1
dica	-	ARTHUR LEE SCOTT, JR.						H 15,			:46 A	IVI
nine	er	4a. Facility Name (If not institution, give street and nur	,	A.T	4b. City, Town, or	Location of	Death		County of [-	
<u> 10.10</u>	- 67	CLINTON NURSING & REHAB 5. Social Security Number 6. Sex	7. Age (In yrs. last		CLINTON If Under 1 Year	If Under 2	4 Hrs. 8. Date of		RINCE		GES e (State or Fore	eian
al or		143-26-1167 1 [□] XM 2□F	72	Yrs.	Months Days	Hours		Day, Year)	936 NI	Country)		igi.
		Usual Residence of Decedent	12				PIARCII	1 e 1	230 MI	EW OF	KOLI	
ì.		10a. State 10b. County	10c. City, T	own or Lo	cation						Inside City Lim	
	덩	MD PRINCE GEORGES	MITC	HELL	VILLE						XXYes 2□	No
		10e. Street and Number			10f. Zip Code			10g. Cit	izen of Wha		?	
	a	10403 MEADOWRIDGE COURT		1:	20721				U.S.			
	Funeral Director	Armed Fo		13. \	Was Decedent of Hi f Yes, specify Cuba	ispanic Orig ın, Mexican,	in? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - / Black, \	American White, etc.		
		1 XNever Married 2 Married 1 Yes 3 Widowed 4 Divorced 1 Yes, Giv Year or Div	/e		I∐Yes 2∏No	Specify:			Specify: B	LACK		
1	Completed by	15. Decedent's Education		6a. Deced	lent's Usual Occup	ation		16b. K	ind of Busin	ess/Indus	try	
ŀ	plet	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1	-4or 5+)	(Give life. L	kind of work done o DO NOT use retired	during most ()	of working					
	E	12th	-40(54)	C	ARPENTER				PRIVA	TE		
	BeC	17. Father's Name (First, Middle, Last)			-	18. Mother	's Name (First, Midd	lle, Maiden	Surname)			
	0	ARTHUR LEE SCOTT SR				JANE 1	1ARSHALL					
	1	19a. Informant's Name/Relationship (Type. Print)			,		r or Rural Route Nu				1	
		ELIZABETH F. SCOTT/SISTE				IDGE (COURT MIT					
		20a. Method of Disposition 1 ☐ Burial 2 【▼ Cremation 3 ☐ Removal from	State cem	etery, crer	sition (Name of natory or other plac		Date		ocation - City		, State	
		4 □ Donation 5 □ Other (Specify)	RIVE		CREMATO	1	3-18-2008	1	ERDALE	•		
ouce.		21. Signature of Funeral Service Licensee	N				J.B. JEN ROAD LAND				ME	
	-	23a Part1 Enter the disease o complications that of	aused the death.						FID 20	A	oproximate	_
		23a. Part1. Enter the disease, o complications that c shock, or heart failure. List only one cause on e Immediate Cause (Final				9,		,,		ln O	terval Between nset and Death	ı
n al		disease or condition a. CAR	DIOPULMO		ARREST							
er			ONIC OBS'		TVE DITM	NIADV	DICEACE					
	ē	if any, leading to immediate Due to	or as a consequer		IVE TOLK	JIMKI	DISEASE					
1	Examiner		STAGE R	ENAL	DISEASE							
		resulting in death) Last Due to	or as a consequer	ice of):								
	dical	d. COR	ONARY AR	TERY_	DISEASE							
	Med	IF FEMALE:						T				
	ian/	23b. Was decedent pregnant in the past 12 months?	come pf pregnanc oirth 2 ☐ Fetal de	eath 3	Ectopic pregnancy	,			23d. Date o Month	-	y Year	
-	Physician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregr 9 ☐ Unknown 9 ☐ Unknown	ant at time of deat own	n 5L	Other (specify)			-				
		Part II. Other significant conditions contributing to de	eath but not resulting	ng in the u	nderlying cause give	en in Part I.	23e. D	d tobacco	use contribu	ite to the	cause of death	?
	و	S/P TRACHEOSTOMY, DEEP	VENOUS '	ГHRОМ	BOSIS		1	Yes 2	□ No 3[Probab	ly 4X Unkno	own
	ete	IN LEFT AXILLARY, LEFT	CIIRCI AV	TAN 17	ETN		24a. W	as an	24b. Wei	re autops	/ findings avails	able
	Completed by	IN LEFT AXILLARY, LEFT	DODCLAV.	TVI A	EIN		aı pe	itopsy erformed?	dea	th?	findings availa letion of cause	of
		25. Was case referred to medical		·		26. Place	of Death (Check on	41		Yes 2	X No	
	To Be	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐	Inpatient 2 ER	/Outpatier	t 3□ DOA Oth	er.	sing Home 5□R		6 □Other ((Specify)		
		27. Manner of Death 1 Natural 5 Pending (Mon	of Injury 28 th, Day Year)	Bb. Time o	f 28c. Injur Wor	y at k?	28d. Descri	e how inju	ry occurred			
	atio	2 Accident investigation				Yes 2□N						
1	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place buildi	of injury - At home ng, etc. <i>(Specify)</i>	, farm, str	eet, factory, office		28f. Locatio City or	n (Street ar Town, State	nd Number (e)	or Rural A	loute Number,	
		AN Ordificial Physician To the	has to a form the souls				d =	h	\d			_
	Medical	29a. Certifier (Check only one) 1 X Certifying Physician: To the beand man										
	Me	29b. Signature and title of certifier	nor stated.		29c. Licens			29d. Da	ite signed (/	Month, Da	y, Year)	
					000	650	786	03	/17	120	08	
		30. Name and address of person who completed caus	se of death (Item 2)	3a) (Type,								
		GORDON RAMSEY,MD 9211 S	TUART LAN	NE CL	INTON, MI	2073	5					
Stat	- 67	31. Date filed (Month, Day, Year) 32. F	legistrar's Signatur									
stra		MINU TO FOOD	N A			-844						
1/20	01											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] State Registrar Amended#11perFH FCHD, KS 3/18 Artificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** 'ear avo /Medical 4a. Facility Name (If not institution, give street and number Panels (4p. City, Town, or Location of Death 4c/County of Death Examiner Sis 0/01 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** Ũ1□M 201 Days Year Director 1949 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "natural", or items 23a or 28a-f show treumatic event, the Madical Examiner must be notified at ty⊡Yes 2 No Director Maryland Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 9109 Liberty Road 21133 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after -1 Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 IX Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Natural Resources 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental I Earl Leon Gifft Eloisa Nettie Stitely 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tre Michelle D. Parker / Daughter 1008-A Stone Brook Road, Sykesville, MD 21784 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Resthaven Mem. Gardens 3/20/08 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice ROBERT E. DAILEY & SON FUNERAL HOMES 615 EAST MAIN ST., THURMONT, MD 21788 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cau th. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Proysician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of) Examine that the death certificate be executed physicien and s the burial-transit Due to (or as a consequence of): Physician/Medical attending (23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) the be detached ö 9 Unknown 9 Unknown Ś signed { Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 2 No 3 Probably 4 Dunknown Completed 1 ☐ Yes 24b. Were autopsy findings available rior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has certificate 1 ☐ Yes 2 N Vital 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Other: 4 / North g Home 5 Residence 6 Other (Specify) Hospital: ٩ 1 ☐ Yes 2 💋 🗷 б 1 Inpatient 2 ER/Outpatient 3 DOA ō this funeral 27. Manner Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Division 1 D atural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident In by the To the Funeral Director, 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after 6 Medical 29a. Certifier 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b Signature and title 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month,

			1 - For State Registrar	State of Maryland		artment of H rtificate of L			giene	3 10308
			Decedent's Name (First, Middle, Last)					2. Date of Dea Month		3. Time of Death
	Physici /Medio		WILLIAM F.	SNYDER				March	13, 2008	5:30 A M
	Examin		4a. Facility Name (If not institution, give s				Location of Death		4c. County of D	
			Kline Hospice 5. Social Security Number 6. Sex	House 7. Age (In yrs. Ii	act hirthdayl	Mount If Under 1 Year	Airy If Under 24 Hrs.	9 Date of Birth	Frede	
	Funeral Director			M 2□F 80	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day March I	1.1928 M	Birthplace (State or Foreign Country) aryland
	D		Usual Residence of Decedent							
	anylan show	پ	10a. State 10b. County	.	, Town or Lo					10d. Inside City Limits 1 X Yes 2 □ No
	Ba-f	Directo	Maryland Frederic	ck E	reder					
	with t		10e. Street and Number 90 Waverly D:	r		10f. Zip Code 21701			10g. Citizen of Wha United	
	death	Funeral		2. Was Decedent Ever in U.S	S. 13. V	Was Decedent of Hi f Yes, specify Cubar		cify Yes or No-		merican Indian,
21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23e or 28e-f show other traumatic svent, the Marical Examiner must be natilised at	by Fur	1 Never Married 2 Married 3 🕅 Widowed 4 Divorced	Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Korea	.	f Yes, specify Cubai 1 □ Yes 2 🛣 No	Specify:	Rican, etc.)	Specify:	/hite, etc. White
2-0	natur icel	Completed by	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Deced	ient's Usual Occupa	ition Juring most of worki	na	16b. Kind of Busine	ess/Industry
2	han ne.	mple	Elementary/Secondary (0·12)	College (1-4or 5+)		kind of work done d DO NOT use retired, itation D		9	City Gove	rnment
72	tygier ther ti		17. Father's Name (First, Middle, Last)			Ttation D	18. Mother's Name	/First Middle		ETIMETIC
and	d be f	Be c	Joseph	Snyder			Carmie	(First, Middle,	Seirf	
Maryland	should nd Me mark imatic	오	19a. Informant's Name/Relationship (Typ		19b. Mailin	ng Address (Street a	and Number or Rura	l Route Numbe	r, City or Town, Sta	re, Zip Code)
Ž	alth al 27 is		Richard A. Snyder	/ Son	109 C	apricorn	Rd. / Wal	kersvil	lle, MD	21793
Jre,	of Hei		20a. Method of Disposition	20b. PI	ace of Dispo metery, cren	sition (Name of natory or other place	g) C	ate	20c. Location - City	or Town, State
Ĕ	Page nent ant: H		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)			n Mem.Garo		/2008	Frederick	,Maryland
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		21. Signature of Funeral Service License	Palan and					Funeral Ho ederick, N	
			23a. Part 1 Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death	. Do not ente	er the mode of dying	g, such as cardiac o	r respiratory ar	rest,	Approximate Interval Between
z	Physician		Immediate Cause (Final disease or condition	Abdo-	21 / 21 =	1 (30	er em m m	m / n.		Onset and Death
	/Medical		resulting in death)	Due to (or as a consequ		(())	21402	0, 1, 0;		7
	Examiner		Sequentially list conditions, b							
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a consequ	ence of):					
	icate be executed physician and s the burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequ	ence of):					
68760,	siciar siciar s buris	alE	L _a							
_		edical	<u>'</u>						I	
Box	that the death certifed by the attending detached for use an	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	ac. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
<u>Р</u> .	at the by th tache	hys	9 Unknown	9L] Unknown						
	w requires the been signed should be de	ρ	Part II. Other significant conditions con	tributing to death but not resu	lting in the ur	nderlying cause give	n in Part I.	23e. Did to	_	e to the cause of death? Probably 4 Dunknown
Division of Vital Records,		Completed						24a. Was a autop perfor 1 Tes	sy prior med? deat	
ta	hyeician: The la his certificate ha I director, page 2	BeC	25. Was case referred to medical examiner?				26. Place of Death			
×	Phyeic this ce al dire	P	1 ☐ Yes 2€ No	The state of the s	R/Outpatien		4 Nursing nor			Specify) / topice
Ž	Attending Physician: If death. Sctor: After this certific. by the funeral director,	on:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c, Injury Work	?	28d. Describe h	ow injury occurred	14 ouse
Sic	or Attend after death Director: , in by the f	cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At hor	no farm ste		res 2□No	28f Location /S	Street and Number o	r Rural Route Number,
<u>></u>	2 = 5	Certification:	4 Homicide determined	building, etc. (Specify,)	sei, lactory, office		City or Tow		riara riodo italiaor,
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral			icien: To the best of my know						
	hs Hc in 24 he Fu pietely	edical	(Check only 2 Medicel Exemin	er: On the basis of examinati and manner stated.	on and/or inv	estigation, in my op	inion, death occurre	ed at the time, o	date and place, and	due to the cause(s)
	To t To t	Σ	29b. Signature and title of pertifier	and mr		29c. License	number		29d. Date signed (M	
				111/	7	0146	26.	4	Mar 1	3,2008
1	2+1		30. Name and address of person who cor $P \text{.} Gregory \ Raus$				rederick	, Maryla	and 21701	
	Sta		31. Date filed (Month, Day, Year)	32. Registra s Signati	Lo	Keed p				
	Registr	ar	MAR 1 8	3 2008 Page	, 13.	A STATE OF THE STA				

		1 - For State Registrar	State of Maryla	nd / Depa	ırtment d	of Health and I	Mental Hygi	ene () () 8	10309
		Decedent's Name (First, Middle, Last)				0, 2000.	2. Date of Death		3. Time of Death
Physicia		PoloRes	ScHULT				Month	Day Year	
/Medic		4a. Facility Name (If not institution, give s		>	4b. City. Toy	wn, or Location of Deatl	March	15, 2008 4c. County of Dea	0.20 A
Examine	٠,	Upper Chesapeake I	ledical Conti	2 11	Roll	2 Air		Harford	1
Funeral		Social Security Number 6. Sex	7. Age (In yrs	s. last birthday)	If Under 1 Y	ear If Under 24 Hrs.	8. Date of Birth (Month, Day,)		rthplace (State or Foreign country)
Director		265-40-6486 Usual Residence of Decedent	IM 2 ⊠ F 76	Yrs.	Months D	ays Hours Min.	08/03/1	931 Ma	ryland
yland		10a. State 10b. County	10c. C	City, Town or Loc	cation				10d. Inside City Limits
death with the Maryland me 23a or 28a-f show rmust be notified at	ţo	MD Harford	d I	Havre de	2 Grace	2			1 X Yes 2 ☐ No
or 284	Funeral Director	10e. Street and Number	-		10f. Zip Co	ode	109	g. Citizen of What C	country?
th wi	a	952 Chesapeake Dr	ive.			21078		U.S.A.	
r dea	ner		2. Was Decedent Ever in Armed Forces?	U.S. 13. W	Vas Decedent	t of Hispanic Origin? (S Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Am Black, Wh	erican Indian,
36 after or It	F	1 Never Married 2 Married	1 ☐ Yes 2V No If Yes, Give		☐Yes 2☐		o 7ou., 0.0.,		Ihite
5-0036 72 hours at natural; or acceptant	d by	3 XWidowed 4 Divorced	Year or Dates:						
28 2036 1215-0036 within 72 hours after ane. than "natural", or Ite	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	(Give I	ent's Usual O kind of work a OO NOT use n	lone during most of wor	king	3b. Kind of Busines:	s/Industry
212 212 d withi giene.	mc	Efementary/Secondary (0-12)	College (1-4or 5+)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			l l	11.000	
A Liled A 20 Ont.		17. Father's Name (First, Middle, Last)			Homen		ne (First, Middle, Ma	HOME.	
ld be ental	To Be	Fred Gillotte				Danath	y Laye		
Maryland nd 2 should be filt and Mental Hy 27 Is marked oth raumatic event	H	19a. Informant's Name/Relationship (Ty)	oe, Print)	19b. Mailine	g Address (St	treet and Number or Ru		City or Town, State,	Zip Code)
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23a or 28a-1 show any injury or other traumatic event, the Medical Examinational be notified at once.		Suzanne Schultz (laughter)		_	eake Drive,			
other other	Ì	20a. Method of Disposition	20b.	Place of Dispos	sition (Name o	of r place)	Date 20	oc. Location - City o	r Town, State
SIIS Baltimor Bernit. Pages Department of the Important: If the any injury or of one		1 ☐ Burial 2 ☐ Cremation 3 ☐ R. 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	•	•	., Inc. 03/	20/2008	West Ches	ton PA
Balti Bearin Departin Imports any inju		21 State of Funeral Service License					ellman Fu		
/) w #9E # 8	1	Jaua C.	sellman	K, 12	23 S. U	vashington	St. Haure	de Grace	, MD 21078
		23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	ations that caused the dea	ath. Do not ente	er the mode of	f dying, such as cardiac	or respiratory arres	t,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	14/6	PARD	1 Al	NEARNY	(AL)		Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a conse	equence of):		NFARCT RY DISC			1.0
		Sequentially list conditions, b	CORO	VARY	ARTE	RY DISC	le		WYELR
pe is:	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	iquence of):		/			
60, be executed iclen and burial-transit	xan	that initiated events cresulting in death) Last	Due to (or as a conse	quence of):					
5 G G G	calE			,					
		_ d							
Box 68 Beath certificat ettending phy	2	IF FEMALE: 23b. Was decedent pregnant	Bc. If yes, outcome of pregr					23d. Date of de	elivery
Geath death defor	Cla	in the past 12 months?	1□Live birth 2□Fe 4□Pregnant at time of		Ectopic pregn Other (specif			Month	Day Year
S, P.O. B. es that the death gned by the ette be detached for	Physician/Med	9 Unknown	9□ Unknown						
ds, F ds, F signed I d be det	by P	Part II. Other significant conditions con	tributing to death but not re	sulting in the un	derlying cause	e given in Part I.	23e. Did toba	cco use contribute	to the cause of death?
Records, P.O. The law requires that the ten has been signed by the page 2 should be detached.		GOPD, CONGO	3TIVE 1484	RT fou	due,	Mulie	1 ☐ Yes	2 □ No 3 □ F	robabiy 4 Unknown
Record Record he law requir	Completed	alpendent Dial	ets, HYPER	Tenno	ni		24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
The same has been as a same has a	000						performe 1 ☐ Yes 24	d? death?	
of Vital F Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?					th (Check only one)		
Of V	၉	TU Yes 21 No	ospitaf: 1 Inpatient 2				ome 5 Residen		ecity) ASZITED
On of Vital Reding Physician: The Infumeral director, page	ertification:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of fniury		Injury at Work?	28d. Describe how	injury occurred	9
	Cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At I	nome farm stro		1 ☐ Yes 2 ☐ No	28f Location /Stre	et and Number or E	Tural Route Number,
Div Alara	ert	4 ☐ Homicide determined	building, etc. (Spec	ify)	er, raciory, on	nce	City or Town,	State)	rara rioute (vamber,
	<u>8</u>	29a. Certifier 1 Certifying Phys	cien: To the best of my kr	owiedge, death	occurred at th	ne time, date and place	, and due to the cau	se(s) and manner a	s stated.
n 24 n 24 he Fu	Medical	(Check only 2 Medical Examin	er: On the basis of examinand manner stated.	ation and/or inve	estigation, in r	my opinion, death occu	rred at the time, date	e and place, and du	e to the cause(s)
Toti within Toti	Σ	29b. Signature and title of certifier			29c. Lie	cense number	290	I. Date signed (Mon	th, Day, Year)
		1//lallal			1.77	40922		2/17/	8
60		30. Name and address of person who cor	npleted cause of death (fte	m 23a) (Type, P	Print)	11 - 1)1	1-	40-
4		21 Date filed (March Day Van	SMAN	10/ 70	guth.	Ullos AUC	14 PALICE	to Medi	421078
State Registra	_	31. Date filed (Month, Day, Year)	32. Registrar's Sign	lature A	And -	•			

			1 - For State Registrar	State of	Maryland		artment o				ental Hy	giene	2008		310
- Ag	Physic	ian	Decedent's Name (First, Middle, L.	ast)							2. Date of De Month	Day	Year	3. Time of	
	/Medi				rie Sar	tin					March	22	2008	0914	AM
	Examir	ner	4a. Facility Name (If not institution, g		nber)		4b. City, To		Location of	of Death		4c. C	County of Dea	th	
	Funcial		SunBridge Care 5. Social Security Number 6.		7. Age (In yrs. la	st birthday)	E1k		If Under	24 Hrs.	8. Date of Bi	rth	Cecil	thplace (State o	or Foreign
	Funeral Director		213-46-1958	1□M 2∏F	90	Yrs.		Days	Hours	Min.	OCT 17	ay, Year) 1917	Vi	ountry) Lrginia	1 1 Groigit
	P .		Usual Residence of Decedent												
arylan show		_	10a. State 10b. County 10c. City, Town or Location									10d. Inside Ci	•		
	Me M	Director	Maryland Cecil Colora 10e. Street and Number 10f. Zip Code									1 🗆 Yes	2 A 140		
	death with the Maryland me 23a or 28a-f show Lisast be notified at			Da. d	1								en of What C		
	heath	Funeral	2086 Liberty G	12 Was Dece	dent Ever in LLS	13		917	nanic Ori	gin? (Spe	ofy Yes or No		niced 4. Race - Ame	States	
	r itame	Fun	1 Never Married 2 Married	Armed For 1 ☐ Yes	ces? 2 🛣 No				, Mexicar	n, Puerto I	cify Yes or No Rican, etc.)		Black, Whi		
93	72 hours after de natural', or Itam	by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Da	Θ		1 □ Yes 2 ∏	No	Specify:			5	Specify:	Vhite	
21215-0036	72 h	Completed	15. Decedent's (Specify only highest of	Education		(Give	dent's Usual C	done du	urina mos	t of workir	na	16b. Kind	d of Business	/Industry	
121		mp	Elementary/Secondary (0-12)	College (1-	-4or 5+)	life.	DO NOT use i	retired)				_	**		
7	Hygie Hygie Ther t	ပိ	17. Father's Name (First, Middle, Las	n#1		Ho	memake	1	10 Moths	r'a Nama	(First, Middle	4		wn Home	
and	d be f ontal f	Be c	Unknown	st/							y Wals			5	
Maryland	12 should be filed within " h and Mental Hygiene. 7 is marked other than " reumatic event, the Mes	10	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	na Address (S	treet ar			Route Numb				
Ma	nd 2 :		Linda M. Gallaher		mohter							-, -, -,	, , , , , , , , , , , , , , , , , , , ,	,	
re,	permit. Pages 1 and 2 should be filed within Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than any lojury or other traumattic event, Illia Mone.		20a. Method of Disposition		20b. Pla	ce of Dispo	sition (Name natory or othe	of	- F	D	ate	20c. Loca	ation - City or	Town, State	
Ë	Page nent of int: if		1 X Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec		otate		Cemete		11.	larch 2008	27,	Che	esanea	ke City	MD
Baltimore,	mit. pertrr porta y inju		21. Signa ure of Funeral Service Lic	ensee]		22	Name and	Address	of Facilit	hv	- 1 F			ne orej	, 110
<u> </u>	89 2 2 8		Donned.	8 Hi	in	10	3 W. S	toc	kton	Stre	cals, F	kton.	_MD2	21921	
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that ca ly one cause on ea	used the death. ich line.	Do not ent	er the mode o	of dying	, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Bet	ween
E.	Physician		Immediate Cause (Final disease or condition	a	Alher	oscle	nosis							Unkno	Jeath h
	/Medical Examiner		resulting in death)	Due to (d	or as a conseque									×	
		-	Sequentially list conditions,	b	9ang	rene								Days	
1	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	500 10 (0	3, 40 a 00,1304 a									, ,	
٧_ َ	execu n and ial-tra	Еха	that initiated events resulting in death) Last	c. Due to (d	or as a conseque	nce of):									
8760,	ate be executed hysician and the burial-transit	dicai		d											
	rtifica ng ph	Med	IF FEMALE:												
Вох	death certifice e attending ph ed for use as t	Physician/Me	23b. Was decedent pregnant		come of pregnand		Ectopic pregi	nancy				23	d. Date of de		V
.O.	0 0 0	sici	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4□Pregna 9□Unkno	ant at time of dea wn		Other (speci						Month	Day 1	Year
P.	that the death ed by the atte detached for	Ph	Part II. Other significant conditions	contributing to de	ath but not result	ing in the w	adorh/ing cau	20 0110	o in Part I		23a Did	tobacco us	a contribute t	o the cause of d	loath?
Records,	sign d be	Completed by	, a	ooning to do	an barnor resun	ang an ano di	loonying caus	o givoi	THIT CITY					robably 4 🖭	
Sor	* requ	ete													
Rec	has ge 2	du.									24a. Was auto perfe		prior to death?	utopsy findings a completion of ca	avallable ause of
a		e C	25. Was case referred to medical						00 81	-4 D N	1 Yes	2 No	1 🗆 Yes	2 No	
5		To B	examiner?	Hospital:	patient 2 E	R/Outpatier	t 3 DOA	Other			(Check only one 5 ☐ Resi		Other (Spe	20:6:1	
Division of Vital	g Phys erthis eral di	n:	27. Manner of Death	28a. Date o		8b. Time of		Injury :			8d. Describe			city)	
ioi	uttending I death. ctor: After / the funer	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigati	on	i, Day 16ai)	Injury	М		es 2 🔲	No					
i≥i	after death after death Director: d in by the	Certification:	3 Suicide 6 Could not 4 Homicide determine	d 286. Place	of Injury - At hom g, etc. (Specify)	e, farm, str	eet, factory, o	ffice		2	8f. Location (City or To	Street and wn, State)	Number or R	ural Route Num	ber,
۵	nital o			di											
	Hosp 4 hou Fune tely fi	ical	(Check only 2 Medical Exe	Physician: To the laminer: On the ba	sis of examinatio	ledge, death on and/or in	occurred at t restigation, in	the time my opi	e, date an nion, dea	d place, a th occurre	nd due to the	cause(s) a date and p	nd manner a place, and du	s stated. e to the cause(s	i)
	To the Hospital or Attending Physikin 54 hours attended to within 24 hours attended to the Funeral Director: After the completely filled in by the funeral	Medical	one) 29b. Signature of title of certifier	and mann	er stated.				number					th, Day, Year)	
	- 3 - 3			MX					332			_	24.0	-	
7	. \		30. Name and address of person who	completed cause	of death (Itom 3	(Sa) (Tuna	Print)	d	フクイ			J.	-(7.6	0	
	4		S.S. Sachder		1/8 N	~#S	f &	7e	38.	E	ekton	MZ)2/9	2/.	
2)	Sta		31. Date filed (Month, Day, Year)		gistrar's Signatu	(8	- 044							-/-	
0	Registr	ar	MAR 3 1 2	008	Care I	40	20								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dorsey Elvin Stoner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington Hagerstown If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 214-09-4753 Usual Residence of Decedent Dec. 26,1917 90 10d. Inside City Limits 10b. County 10c. City. Town or Location 1 ☐ Yes 2 No Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11027 Rosewood Dr. 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 ☐ Divorced White 16a. Decedent's Usual occupation 16b. Kind of Business/Industry 15. Decedent's Education

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any once. Baltimore, Maryland 21215-0036 Physician /Medical

Physician

/Medical

10a. State

MD

Director

ed by Funeral

Examiner

Funeral Director

Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

e	(Specify only highest grade comp.		of work done during most of working OT use retired)								
Complet	1 1 1	llege (1-4or 5+)			,		Mussis				
ပ္	17. Father's Name (First, Middle, Last)	Į.	Piano	runer	18. Mother's Nan	me (First, Middle, Maid	Music len Surname)				
Be							· _	onor			
٩	William Elvin Stoner	-4)	40h Mailina Add	Mary Catharine Hartman Stoner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
	19a. Informant's Name/Relationship (Type. Prin	nt)	l					Zip Code)			
	Charles Stoner / Son	1			Ave. na	igerstown M					
	20a. Method of Disposition 1 XBurial 2 □Cremation 3 □Remova 4 □Donation 5 □ Other (Specify)	I from State	ace of Disposition emetery, crematory st_Haven	or other plac Cemete	ry_ 3/2		Location - City o				
	21. Signature of Funeral Service Licensee		22. Nam	e and Addres	ss of Facility R	Rest Haven	Funeral	Chape1			
	J. Mark Ju	7/0	1601	Penns		Ave. Hager					
	23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus	that caused the death.			•	or respiratory arrest,		Approximate Interval Between Onset and Death			
	Immediate Cause (Final disease or condition resulting in death)	Due to Vr as a conseque	ence of):	far co	un						
		Schsa									
Jer		ina to (ar lia a consequi	ance of):								
Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Clestur	Doller	0. (& Celan						
xa		ue to (or as a conseque	ence of):								
		Rendo	for live	,							
훘	0						-				
by Physician/Medical	in the past 12 months?	es, outcome pf pregnar]Live birth 2 □ Fetal]Pregnant at time of de]Unknown	death 3 □Ectop	ic pregnancy r <i>(specify)</i>			23d. Date of de Month	elivery Day Year			
H.	Part II. Other significant conditions contributing	og to death but not recul	ting in the underlyi	na cause aiv	on in Part I	23e Did tohaco	o use contribute	to the cause of death?			
d by	Part II. Other significant conditions contributing	ig to death but not resul	ung in the underly:	ng cause give	en in Fait i.			contribute to the cause of death? No 3 ☐ Probably 4 ☐ Unknown			
Completed						24a. Was an	24h Were s	autopsy findings available			
m D						autopsy	prior to	completion of cause of			
ပိ						1□ Yes 2 🕅					
Be	25. Was case referred to medical examiner?	li No		0415		ath (Check only one)					
e E	1 Yes 2 No Hospital	IZInpatient 2		DOA Oth	4 🗆 Nursing 🖯	lome 5 ☐ Residence		ecify)			
Medical Certification: To	27. Manner of Death 28a. 1 Natural 5 Pending 2 Accident investigation	. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injur Worl	yat <br Yes 2 □ No	28d. Describe how in	njury occurred				
ertifica ertifica	3 ☐ Suicide 6 ☐ Could not be determined 28e.	. Place of injury - At hor building, etc. (Specify)	me, farm, street, fa	ctory, office		28f. Location (Street City or Town, St	and Number or F ate)	Rural Route Number,			
Ö	29a. Certifier 1 Certifying Physician:	To the best of my know	vledge death occu	rred at the tir	ne date and place	and due to the cause	a(s) and manner	as stated			
edica	(Check only 2 Medical Examiner: Or										
Ž	29b. Signature and title of certifier			29c. Licens	number	29d.	Date signed (Mor	nth, Day, Year)			
	1 Order	MI))46561		TARCH.	24,2008			
	30. Name and address of person who complete	d cause of death (Item:	23a) (Type, Print)	AMA	ROAD	HAGENS	TOWN M	1) 21740			
e ir	31. Date filed (Month, Day, Year) MAR 3 1 2008	32. Registrar's Signato	OTE ADDA	es o							
	-										

Sta Registra 08-02338 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Barry Schomborg 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 1445 hrs March 24, 2008 Medical Examiner BARRY BRITTON SCHOMBORG 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Queen Anne's 500 Piney Narrows Road Chester 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Months Days Hours Director Country) MD MAR 10, 1 X M 2 F 1948 216-48-5420 60 Yrs Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No 28a-f show CHESTER MD QUEEN ANNE'S Director 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 500 PINEY NARROWS ROAD 21619 USA Funeral 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nomust be White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married 1 X Yes 9 Yes 2 No specify 4 XDivorced Specify: WHITE 3 Widowed ģ 16a. Decedent's Usual Dccupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 72.1 other than " 21215-0036 Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. **BUYER/SELLER** MARTNE 1 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) event, 1 it: If item 27 is marked other traumatic event, æ EMIL SCHOMBORG HELEN UNKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD ALLISON SCHOMBORG/DAUGHTER 317 LAUREL ST., EASTON, MD 21601 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 1 Burial 2 X Cremation 3 Removal from State crematory or other place) Department of Important: I CHESAPEAKE CREMATION CTR 3/26/2008 STEVENSVILLE, MD Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Fac FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 (Strousla: 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. Between Onset and /Medical Death Alcohol and diphenhydramine intoxication Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transit executed Physician/Medical X UNPENDED #23a,27,28a-f, perME,g879 5/8/08 TT The law requires that the death certificate be Box 68760. 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Live birth 3 Ectopic pregnancy Fetal death past 12 months Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown g Unknown by the a 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð Yes 2 No 3 Probably 4 V Unknown Completed as been s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has performed? ✓ Yes 2 No 1 🗸 Yes 2 No 26. Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funcral Director: After this certificompletely filled in by the funeral director, 25. Was case referred to medical Be Hospital: 1 examiner? Other Nursing Home 5 Residence 6 VOther: Scene ER/Outpatient 3 DOA Inpatient 2 1 🗸 Yes ٩ No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: Natural Yes 2 X No Pending ımk Fnd 3/24/2008 Fnd 2:38 pm 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc X Could not be 3 Suicide or Town, State) determined (Specify) residence 500 Piney Narrows Rd. Chester, MD Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number DOME O.C.M.E. March 25, 2008 heoden 30. Name and address of person who completed cause dideath (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

State Registra

31. Date filed (Month, Day, Year)

32 Registrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day Physician Month March 14, Kirkor Tomaskesis 2008 2:30pM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Hospice-Casey House Rockville Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday **Funeral** 1**X** M 2 □ F 219-04-4181 Director 78 Jan. 1, 1930 Turkey Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Rockville Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7 Templar Court 20851 Armenian Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. ther than "natural", or ite 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 → Married Maryland 21215-0036 1 ☐ Yes 2 No White þ Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Technician Automobile 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) rmit. Pages 1 and 2 should be filipartment of Health and Mental Hiportant: If item 27 is marked oth y Injury or other traumatic eventy Be Markar Tomaskesis Eva Mihlaycian 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Tomaskesis/Wife 7 Templar Court, Rockville, MD 20851 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State X□ Burial 2 □ Cremation 3 □ Removal from State March 18 permit. Page Department o Important: If any Injury or Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2008 Silver Spring, Maryland 21. Signatural Funeral Service I 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or cor plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only or e cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Cerebral Vascular Accident /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit Due to (or as a consequence of): Box 68760 pe Physician/Medical as attending IF FEMALE: nse yes, outcome pf pregnancy □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year P.O. I the 9□Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Redords, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown funeral director, age 2 should Completed Pneumonia een 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an te has h autopsy 1∐ Yes 2**y**⊡ No Division or Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice 1 ☐ Yes 2 ☐ No 1 | Inpatient 2 ER/Outpatient 3 DOA 2 After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After Certification: 5 ☐Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

Registrar

31. Date filed (Month, Day, Year) MAR

Genevieve Wroblewski, MD

17 2008

Registrar's Signature

w

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(u)

D64615

6001 Muncaster Mill Road, Rockville, MD 20855

March 14, 2008

			For State Registrar		State	of Maryl		artment e ertificate			ental Hygi	iene 0 0	8	10314
			1. Decedent's Name	e (First, Middle	, Last)						2. Date of Deatl	1		3. Time of Death
	Physicia		HELEN	L.	THURMAN						Month MARCH	Day 15 20	Yeer 008	10:15 A M
	/Medic Examin		4a. Fecility Name (/			ımber)		4b. City, To	wn, or Loca	ation of Deeth		4c. County of Deeth		
	Examin	er			eneral Ho				lney			Mont	gome	ery
			5. Sociel Security N		6. Sex		rs. last birthday		_	Inder 24 Hrs.	8. Date of Birth		9. Birth	plece (State or Foreign
	Funeral Director		217-58-0		1□M 2 X F	95	.,	Months [Days Ho	ours Min.	(Month, Day, Oct. 15	Year) 1912	Cou	irginia
	-	.	Usuel Residence of								000. 10			
	land ow		10a. State	10b. County		10c	City, Town or I	ocation						10d. Inside City Limits
	Man F	Po										1 ☐ Yes 2 📉 No		
	28a	Director	10e. Street and Nur	mber				10f. Zip C	ode		10	Og. Citizen of W	/hat Cou	intry?
	Net Pa	0	613 01	nov-Sar	ndy Sprin	r Road			2	20860		United	st:	ates
	99th	Funerai	11. Marital Status	ney-sar		cedent Ever i		. Was Deceder			cify Yes or No-			ican Indien,
_	iten iten	5	1 Never Marr	iod 2 □ Marn	Armed F	orces? 2 🐼 No		Il Yes, specify	Cuban, Me	exican, Puerto I	cify Yes or No- Rican, etc.)	Blec	k, White,	, etc.
5	irs al	by	3 Nidowed		If Yes, G Year or	ive		1 ☐ Yes 2	No Sp	ecify:		Specify.	· Wh:	ite
5	hou	ed		15. Decedent	's Education		16a. Dec	edent's Usual (Occupation		1	16b. Kind of Bu	siness/Ir	ndustry
2	n. r	ojet		cify only highes	st grade completed		(Giv	e kind of work of DO NOT use	done during	g most of workii	ng			·
7	the the	Completed	Elementary/Seco	ondary (0-12)	College	(1-4or 5+)	Но	memaker	<u>-</u>			Own I	Home	
3	Hygin ther		17. Father's Name	(First, Middle,					18.1	Mother's Name	(First, Middle, N	Aaiden Sumam	e)	
0		o Be	Lawren	ce Ma	nuel S	uter				Emma	Pearl	Showal	lter	
	nati	은	19a. Informant's N		hip (Type, Print)		19b. Mai	ling Address (S	Street and A	Number or Rura	l Route Number,	City or Town.	State, Zi	p Code)
Z :	d 2 s th an th an treu				man / So	n					Damascu	_		872
	1 and Health em 27 ither tr		20a. Method of Dis				b. Place of Disp	osition (Name	of		ate	20c. Location -	City or T	own, State
5	Peges nent of t int: If its iry or o		1 🔀 Burial 2	Cremation	3 Removal from	State		ematory or othe		3/2	0/08	Burto	າຊນາ	lle, Md.
	t Perturber rtant		* 4 □Donation				Union C			1			.15 v 1.	110, 1141
Dal	permit. Peges 1 and 2 should Department of Health and Men Important: if item 27 ie marke eny injury or other treumatic. <u>once.</u>		21. Signature of Fu			, ,			H. H	Barber .	Funeral	Home	4.5	20002
_	40200				1	ark		P. O.			Laytonsv		MCI.	Approximate
	5 5 6		shock, or hea	ne disease, or in lailure. List	complications that only one cause on	each line.	leath. Do not e	nter the mode of	oi aying, sui	ch as cardiac c	r respiratory arre	est,		Interval Between Onset and Death
F	hysician		Immediate Cause disease or condition		a S	evere	Multi I	obar Pi	neumor	n i a				
*	/Medical Examiner		resulting in death)		Due to	(or as a con	sequence of):							
	-xammer		Sequentially list co	enditions.			tory Fa	ilure						
	D :=	ine	if any, leading to in cause. Enter Under	nmediate erlying	Due to		sequence of):							
	acute ind trans	Examiner	Cause (Disease or that initiated events resulting in death)	\$	C	c. Non-ST Elevation M I Due to (or as a consequence of):								
50.	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Ě	resulting in death)	Last		•	sequence of): .e Elect	-rolute	Ahno	rmaliti	A S			
	ate b hysic he b	dical			d	urcipi	e Fieci	roryte	ADIIO.	LINALICI				
5	death certifical attending partition at for use as the	Med	IF FEMALE:	-	1	-								100000
5	th ce tendi	an/	23b. Was deceden		23c. If yes, o	utcome of pre		☐Ectopic preg	inancy			23d. Dat		*
	ires that the death cer signed by the attendir d be detached for use	Physician/Me	in the past 12	No		nant at time		Other (spec				Mor	iui	Day Year
,	by the	h	9 🗌 Unknown	1	32011									
Ď.	as the	by F	Part II. Other signif	ficant condition	ons contributing to	death but not	resulting in the	underlying cau	se given in	Part I.	23e. Did tob	\ A		the cause of death?
2	w require										1 🗆 Ye	s 2 No	3 Pro	bably 4 Dunknown
ָ 2	law requas been 2 shouk	Completed									24a. Was a			opsy findings available
֓֞֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	he lav e has age 2	mo									autops perform	79 4 ?	leath?	ompletion of cause of
	certificate rector, pag	O	25. Was case refer	rred to medical					26	Place of Death	(Check only on			2 110
> :	sicie s cert lirect	00	examiner? 1 ☐ Yes 2 🛣	,	Manadali	Inpatient	2 🗆 ER/Outpati	ent 3 DOA	Other		ne 5 Reside		ar (Snec	ih)
5 7	r this	To :	27. Manner of Deat		28a. Date	of Injury	28b. Time	of 280	. Injury at		28d. Describe ho			,/
5 .	tune fune	ţ	1 Natural 2 ☐ Accident	5 Pendin	9	nth, Day Yea	r) Injury	М	Work? 1 ☐ Yes	2 🗆 No				
2	dea dea ctor y the	fica	3 Suicide	6 Could	ined 200. Flat	e of Injury -	At home, farm, s	street, lactory, o	office				er or Rur	ral Route Number,
Ŝ.	after Dire	Certification:	4 🗍 Homicide	GOTOTT	buil	ding, etc. (Sp	ecity)				City or Town	, State)		
	spita lours neral		29a. Certifier	1 Certifyin	g Physician: To th	e best of my	knowledge, dea	ath occurred at	the time, da	ate and place, a	and due to the ca	iuse(s) and ma	nner as :	stated.
:	o the Hospital or Attanding Physicien: within 24 hours after death, o the Funeral Director. After this certific ompletely filled in by the funeral director.	edicai	(Check only one)	2 Medical	Examiner: On the and ma	basis of exar nner stated.	nination and/or	investigation, in	my opinior	n, death occurr	ed at the time, da	ate and place, a	and due	to the cause(s)
	To the Mospital or Attending Physicien: The within 24 Hours after death, within 24 Hours after death, To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Me	29b. Signature and	title of certifie					license nun			9d. Date signed	(Month	Day, Year)
				7			(aa)	D	006	2265		Marc	h 16	2008
	9		30. Name and add	ress of person	who completed car	use of death	(Item 23a) (Type							
	5		montan	n Gene	red Horn	1	18/01/	Prince	The	len Len	Olne	, md	Zo	832
	Sta	te	31. Date filed (Mon	nth, Day, Year)	32	Registras S	ignature	1	d -	1		/		
	Registr	-	30. Name and addi	MAR	T 8 2008	Blue	the case	STACE OF						
						-								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physicia		I- For State Registrar		Certific	ate of Death		F	leg. No.	4 U U	0 1001	
	an/	Decedent's Name (First, Middle,Li	ast)				2. Date of Dea	ath Day	Year	3. Time of Death 1617 hrs	
ai Exami	ner	CARL LEO THOMAS		 	14.00.7		March 21	, 2008	inty of Death	1017 Nrs	
		4a. Facility Name (if not institution, g Shady Grove Adventist I			4b. City, Town, o	or Location of L	Death	1	gomery		
Funeral				e (in yrs. last bir		ear If Under 2	24Hrs. 8. Date of B				
Director		218-17-6174 N	XXM 2 F	32	Yrs. Months Da		Min. 03/30	,	Foreigi	n untry) SPAIN	
ŕ	ŀ	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town				10d. Inside City Limits			
nd show a		MD MONTGON	/FRV	GAITHE			1	1 X Yes 2 No			
yland a-f sh t onc	홠	10e. Street and Number		10g. Citizen o	of What Coun	ntry?					
or 28	ire			. DE #20	10f. Zip Code					•	
ith th	Funeral Director	18700 WALKERS CI	12. Was Decedent		1 20886		1? (Specify Yes or N	USA 0- 14.1	Race - Americ	can Indian, Black,	
and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiand teems 23 or 28a-f she trem 27 is marked other than "natural", or items 23a or 28a-f she trammatic event, the Medical Examiner must be notified at once	ner	1 Never Married 2 Married	Armed Forces?		If Yes, specify Cub				White, etc.		
re de		3 Widowed 4 Divorce	1 Yes 2 ed If Yes, Give Year	X No	1 Yes 2X N	lo specify:		Spe	cify: BLA	CK	
urs af tural amin	d b	15. Decedent's Education (Specify	or Dates:	npleted) 16a.	Decedent's Usual Occup	ation (Give kir			of Business/I		
72 ho	Completed	Elementary/Secondary (0-12)	College (1-4 or 5	5+)	during most of working li	fe. DO NOT us	se retired)				
r than	ldu		2 YEARS	C	ONTRACTOR			PRI	VATE		
Mental Hygien marked other c event, the Me	S	17. Father's Name (First, Middle, La	st)			18.Mother's	Name (First, Middle	Maiden Surr	name)		
be to ental I rked rent,	Be	CARL L. THOMAS,			<u> </u>		N CLEVELA				
hould nd Me is ma	Ţ	19a. Informant's Name/Relationship		100	b. Mailing Address (Str				Town, State	, Zip Code)	
nd 2 s ulth ar m 27 auma		MONICA THOMAS/WI	LFE		917 2ND STR		NHAM, MD .		tion - City or	Town State	
S l ar of Hea If ite		20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal from Sta		of Disposition (Name of o story or other place)				•		
Page nent c		4 Donation 5 Other Spec			AND NATIONA	L	03/28/200	LAU	KEL, M	Д	
permit. Pages I and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other injury or other traumatic event, the M		21. Signature of Funeral Service Lic	ensee		22. Name and Addre	ess of Facility	J.B. JENI	KINS F	UNERAL	HOME	
8 Q = E	3.3	V neury	dus		7474 LAND						
ysician		23a. Part I. Enter the disease or confailure. List only one cause on		the death. Do n	ot enter the mode of dyin	ig, such as car	diac or respiratory a	rrest, shock,	or heart	Approximate Interva Between Onset and	
Medical caminer	S 103		a <u>Multiple In</u>							Death	
		or condition resulting in death)	Due to (or as a conse	equence of):							
	<u> </u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	editence of).							
	ii	cause. Enter Underlying Cause	C.	oquoneo or,					=		
		(Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence of):							
d Sit	ı	events resulting in death) Last				1. /22 /00					
ecuted and transit	al Examiner		d1_0	2 22 20	C ME 070	41//////					
		X UNPENDED		3a,27,28a	-f per ME g878	- 7/22/00	ann				
ate be exe ohysician a ne burial -	Medical	X UNPENDED	AMENDED 1,2		/				ate of delivery		
ate be exe ohysician a ne burial -	Medical	X UNPENDED	AMENDED 1,2	me of pregnancy	2 Fetal death		pregnancy	23d. Da		y Day Year	
ate be exe ohysician a ne burial -	Medical	X UNPENDED IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcor Live birth Pregnant at	me of pregnancy	,						
ate be exe ohysician a ne burial -	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcor Live birth Pregnant at Unknown	me of pregnancy	2 Fetal death 5 Other (Specify)	3 Ectopic p	pregnancy	Moi	nth [
ate be exe ohysician a ne burial -	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkno	23c. If yes, outcor Live birth Pregnant at Unknown	me of pregnancy	2 Fetal death 5 Other (Specify)	3 Ectopic p	pregnancy t1. 23e. Did	Mon tobacco use	contribute to	Day Year	
ate be exe ohysician a ne burial -	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkno	23c. If yes, outcor Live birth Pregnant at Unknown	me of pregnancy	2 Fetal death 5 Other (Specify)	3 Ectopic p	t I. 23e. Did	tobacco use es 2 ✓ No	contribute to	Day Year the cause of death? bably 4 Unknown	
ate be exe ohysician a ne burial -	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkno	23c. If yes, outcor Live birth Pregnant at Unknown	me of pregnancy	2 Fetal death 5 Other (Specify)	3 Ectopic p	pregnancy 23e. Did 1 Y 24a. Wa and yell per	tobacco use es 2 V No s an apsy formed?	contribute to 3 Prot 24b. Were au prior to death?	the cause of death? bably 4 Unknown utopsy findings available completion of cause of	
ate be exe ohysician a ne burial -	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkno	23c. If yes, outcor Live birth Pregnant at Unknown	me of pregnancy	Petal death Control of the second of the se	Bectopic p	23e. Did 1 Yes	tobacco use es 2 V No s an apsy formed?	contribute to 3 Prot 24b. Were au	the cause of death? bably 4 Unknown utopsy findings availabl completion of cause of	
ate be exe ohysician a ne burial -	Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknoth Part II. Other significant condition 25. Was case referred to medical examiner?	AMENDED 1,22 23c. If yes, outcor 1 Live birth 4 Pregnant at 9 Unknown as contributing to deat	me of pregnancy time of death	Petal death Description of the first section of th	e given in Part	23e. Did 1 Yes 24a. Wa aut 1 Yes Check only one)	tobacco use es 2 No s an opsy formed? 2 No	contribute to 3 Prot 24b. Were at prior to death? 1 Ye	the cause of death? bably 4 Unknown utopsy findings availabl completion of cause of	
ate be exe ohysician a ne burial -	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkno Part II. Other significant condition 25. Was case referred to medical examiner? 1 ✓ Yes 2 No	23c. If yes, outcor Live birth Pregnant at 9 Unknown s contributing to deat	me of pregnancy time of death h but not resulting	Petal death Dutpatient 3 DOA	e given in Part	23e. Did 1 Yes 24a. Wa aut 1 Yes Check only one) Nursing Home 5	tobacco use es 2 V No s an apsy formed?	contribute to 3 Prot 24b. Were at prior to a death? 1 Y	the cause of death? bably 4 Unknown utopsy findings availabl completion of cause of	
ing Physician: The law requires that the death certificate be exe After this certificate has been signed by the attending physician a funeral director, page 2 should be detached for use as the burial -	To Be Completed by Physician/Medical	X UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkno Part II. Other significant condition 25. Was case referred to medical examiner? 27. Manner of Death	23c. If yes, outcor Live birth	me of pregnancy time of death h but not resulting ent 2 ER/Curry (ear) 28b.	Petal death County of Imperior of Imperior of Injury Petal death County of Imperior of Injury Petal death County of Injury Petal death County of Injury Petal death County of Injury Petal death County of Injury Petal death County of Injury Petal death County of Injury Petal death County of Injury Petal death County of Injury Petal death County of Injury Petal death County of Injury Petal death County of Injury Petal death County of Injury Petal death County of Injury Petal death County of Injury Petal death County of Injury Petal death County of Injury Petal death County of Injury Petal death Petal death County of Injury Petal death	e given in Part	23e. Did 1 Y 24a. Wa aut per 1 Yes Check only one) Nursing Home 5 28d. Describ	tobacco use es 2 No s an opsy formed? 2 No	contribute to 3 Prot 24b. Were at prior to a death? 1 Y	the cause of death? bably 4 Unknown utopsy findings availabl completion of cause of	
ing Physician: The law requires that the death certificate be exe After this certificate has been signed by the attending physician a funeral director, page 2 should be detached for use as the burial -	To Be Completed by Physician/Medical	X UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkno Part II. Other significant condition 25. Was case referred to medical examiner? 1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investig	AMENDED 1,22 23c. If yes, outcor 1 Live birth 4 Pregnant at 9 Unknown Is contributing to deat Hospital: 1 Inpatie 28a. Date of Inju (Month, Day, V) 3/21/08	time of pregnancy time of death h but not resulting the property of the pregnancy (rear) 28b. 3:	Petal death Control of the pe	e given in Part ace of Death (C	23e. Did 1 Yes 24a. Wa aut per 1 Yes Check only one) Nursing Home 5 28d. Cescrib	tobacco use es 2 No s an opsy formed? 2 No Residence e how injury of	contribute to 3 Prot 24b. Were au prior to death? 1 Ye 6 Othe	the cause of death? bably 4 Unknown utopsy findings availabl completion of cause of es 2 No	
ing Physician. The law requires that the death certificate be exe After this certificate has been signed by the attending physician a funeral director, page 2 should be detached for use as the burial -	To Be Completed by Physician/Medical	X UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkno Part II. Other significant condition 25. Was case referred to medical examiner? 1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Pending Investig 3 Suicide 6 X Could in determine the past 12 months.	AMENDED 1,22 23c. If yes, outcor 1 Live birth 4 Pregnant at 9 Unknown Is contributing to deat Hospital: 1 Inpatie 28a. Date of Inju (Month, Day, Yang) 3/21/08 28e. Place of Ir	ent 2 ER/C	Petal death Control of the following cause o	e given in Part ace of Death (C	23e. Did 1 Yes 24a. Wa aut 1 Yes Check only one) Nursing Home 5 28d. Describ No Unk 28f. Location	tobacco use es 2 No s an opsy formed? 2 No Residence e how injury of	contribute to contribute to 3 Prot 24b. Were at prior to death? 1 Y 6 Othe Occurred	the cause of death? bably 4 Unknown utopsy findings availabl completion of cause of es 2 No r:	
ing Physician. The law requires that the death certificate be exe After this certificate has been signed by the attending physician a funeral director, page 2 should be detached for use as the burial -	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkno Part II. Other significant condition 25. Was case referred to medical examiner? 1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investig 3 Suicide 6 X Could n determit 29a. Certifier	AMENDED 1,22 23c. If yes, outcor 1 Live birth 4 Pregnant at 9 Unknown is contributing to deat Hospital: 1 Inpatie 28a. Date of Inj. (Month, Day, 1) 3/21/08 28e. Place of Ir (Specify) Apa	ent 2 ER/Cury 28b. njury - At home, retrieved to the second control of the second contr	Fetal death Control (Specify) 26.Pla 26.Pla Dutpatient 3 DOA Time of Injury 28c. Ir 32p 1 farm, street, factory, official	e given in Part ace of Death (0 Other4 njury at Work? Yes 2 X t e building, etc.	23e. Did 1 Yes 24a. Wa aut per 1 Yes Check only one) Nursing Home 5 28d. Cescrib No Unk 28f. Location 18700 Wa	tobacco use es 2 No s an apsy formed? 2 No Residence e how injury of (Street and I State)	contribute to 3 Prot 24b. Were au prior to o death? 1 V Y 6 Othe Docurred	the cause of death? bably 4 Unknown utopsy findings availabl completion of cause of es 2 No r: ural Route Number, Cit d, Caithersbur	
ing Physician. The law requires that the death certificate be exe After this certificate has been signed by the attending physician a funeral director, page 2 should be detached for use as the burial -	Certification: To Be Completed by Physician/Medical	X UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkno Part II. Other significant condition 25. Was case referred to medical examiner? 1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Pending Investig 2 Accident Investig 3 Suicide 6 X Could in determit 29a. Certifier 1 Certifying Physical	AMENDED 1,2 23c. If yes, outcor 1 Live birth 4 Pregnant at 9 Unknown Is contributing to deat 28a. Date of Injute (Month, Day, Variation and Death (Specify) Apair sician: 16 the best of mer; 27 the basis of exa	ent 2 ER/C Liry 28b. Signify - At home, yellow by knowledge, de	Petal death Control of the following cause o	e given in Part acc of Death (C Other; injury at Work? Yes 2 X I e building, etc.	23e. Did 1 Yes 24a. Wa aut 1 Yes Check only one) Nursing Home 5 28d. Describ Unk 28f. Location 18700 We te, and due to the ca	tobacco use es 2 No s an opsy formed? 2 No Residence e how injury of State) State use(s) and m	contribute to 3 Prot 24b. Were au prior to a death? 1 Ye 6 Othe Docurred Number or Ru anner as state	the cause of death? bably 4 Unknown utopsy findings availabl completion of cause of es 2 No r: ural Route Number, Cit d , Gaithersbur	
ting Physician: The law requires that the death certificate be exe. After this certificate has been signed by the attending physician a funeral director, page 2 should be detached for use as the burial-	To Be Completed by Physician/Medical	X UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkno Part II. Other significant condition 25. Was case referred to medical examiner? 1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Pending Investig 2 Accident Investig 3 Suicide 6 X Could in determit 29a. Certifier 1 Certifying Physical	AMENDED 1,22 23c. If yes, outcor 1 Live birth 4 Pregnant at 9 Unknown 1s contributing to deat 28a. Date of Injugation 1st to be a light of the best of med 28c. Place of Iright (Specify) Apaces 3/21/08 28c. Place of Iright (Specify) Apaces 3/21/08 28c. Place of Iright (Specify) Apaces 3/21/08 28c. Place of Iright (Specify) Apaces 3/21/08 28c. Place of Iright (Specify) Apaces 3/21/08 28c. Place of Iright (Specify) Apaces 3/21/08 28c. Place of Iright (Specify) Apaces 3/21/08 28c. Place of Iright (Specify) Apaces 3/21/08 28c. Place of Iright (Specify) Apaces 3/21/08 28c. Place of Iright (Specify) Apaces 3/21/08 28c. Place of Iright (Specify) Apaces 3/21/08 28c. Place of Iright (Specify) Apaces 3/21/08 28c. Place of Iright (Specify) Apaces 4/21/08 28c. Place of Iright (Specify) Apaces	ent 2 ER/C Liry 28b. Signify - At home, yellow by knowledge, de	Fetal death Control (Specify)	e given in Part acc of Death (C Other; injury at Work? Yes 2 X I e building, etc.	23e. Did 1 Yes 24a. Wa aut 1 Yes Check only one) Nursing Home 5 28d. Describ Unk 28f. Location 18700 We te, and due to the ca	tobacco use es 2 No s an popsy formed? 2 No Residence e how injury of (Street and I State) Likers Cuse(s) and m te and place,	contribute to 3 Prot 24b. Were au prior to death? 1 Ye 6 Othe Doccurred Number or Ru Anoice Ru anner as stat and due to th	the cause of death? bably 4 Unknown utopsy findings availabl completion of cause of es 2 No r: ural Route Number, City d, Caithersbur	
ing Physician: The law requires that the death certificate be exe After this certificate has been signed by the attending physician s tuneral director, page 2 should be detached for use as the burial -	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkno Part II. Other significant condition 25. Was case referred to medical examiner? 1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investig 3 Suicide 6 X Could in determited to the condition of	AMENDED 1,2 23c. If yes, outcor 1 Live birth 4 Pregnant at 9 Unknown Is contributing to deat 28a. Date of Injute (Month, Day, Variation and Death (Specify) Apair sician: 16 the best of mer; 27 the basis of exa	ent 2 ER/C Liry 28b. Signify - At home, yellow by knowledge, de	Petal death Country 2 Fetal death 5 Other (Specify) 26.Pta Dutpatient 3 DOA Time of Injury 28c. Ir 32p 1 farm, street, factory, office ilding eath occurred at the time, investigation, in my opini	e given in Part ace of Death (C Other jury at Work? Yes 2 X date and plac ion, death occi	23e. Did 1 Yes 24a. Wa aut 1 Yes Check only one) Nursing Home 5 28d. Describ Unk 28f. Location 18700 We te, and due to the ca	tobacco use es 2 No s an opsy formed? 2 No Residence e how injury of (Street and I State) alkers (use(s) and m the and place, 29d. Date	contribute to 3 Prot 24b. Were au prior to death? 1 Ye 6 Othe Doccurred Number or Ru Anoice Ru anner as stat and due to th	the cause of death? bably 4 Unknown utopsy findings availabl completion of cause of es 2 No er: ural Route Number, City d, Caithersbur ted ted ted cause(s)	
To the Hospital or Attending Physician: The law requires that the death certificate be exe within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician a completely filled in by the funeral director, page 2 should be detached for use as the burial -	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkno Part II. Other significant condition 25. Was case referred to medical examiner? 1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investig 3 Suicide 6 X Could in determit 29a. Certifier 1 Certifying Physical Condition 29b. Signature and title of certifier	AMENDED 1,22 23c. If yes, outcor 1 Live birth 4 Pregnant at 9 Unknown as contributing to deat 28a. Date of Injut (Month, Day, 1) 3/21/08 28e. Place of Ir (Specify) Apar and manner stated.	ent 2 ER/C Injury - At home, rtment Burny by knowledge, demination and/or	26.Pia Dutpatient 3 DOA Time of Injury 28c. Ir 32p farm, street, factory, officilding eath occurred at the time, investigation, in my opini	e given in Part acc of Death (C Other; Yes 2 X t e building, etc. date and plac ion, death occions ense number	23e. Did 1 Yes 24a. Wa aut 1 Yes Check only one) Nursing Home 5 28d. Describ Unk 28f. Location 18700 We te, and due to the ca	tobacco use es 2 No s an opsy formed? 2 No Residence e how injury of (Street and I State) alkers (use(s) and m the and place, 29d. Date	contribute to contribute to 3 Prot 24b. Were at prior to a death? 1 Ye 6 Othe Coccurred Number or Ru Anner as stat and due to the e signed (Mo	the cause of death? bably 4 Unknown utopsy findings availabl completion of cause of es 2 No er: ural Route Number, City d, Caithersbur ted ted ted cause(s)	
ing Physician: The law requires that the death certificate be exe. After this certificate has been signed by the attending physician a funeral director, page 2 should be detached for use as the burial -	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkno Part II. Other significant condition 25. Was case referred to medical examiner? 1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investig 3 Suicide 6 X Could in determit 29a. Certifier 1 Certifying Physone) 2 Medical Examination 29b. Signature and title of certifier	AMENDED 1, 2. 23c. If yes, outcor 1 Live birth 4 Pregnant at 9 Unknown as contributing to deat 28a. Date of Injut (Month, Day, Yang) 3/21/08 28e. Place of Ir (Specify) Apa 28c. Place of Ir (Specify) Apa 28c. Place of Ir (Specify) Apa 28c. Place of Ir (Specify) Apa 28c. Place of Ir (Specify) Apa 28c. Place of Ir (Specify) Apa 28c. Place of Ir (Specify) Apa 28c. Place of Ir (Specify) Apa 28c. Place of Ir (Specify) Apa 28c. Place of Ir (Specify) Apa 28c. Place of Ir (Specify) Apa 28c. Place of Ir (Specify) Apa	ent 2 ER/C Injury - At home, interest But how when the summation and/or death (Item 23a)	26.Pia Dutpatient 3 DOA Time of Injury 28c. Ir 32p farm, street, factory, officilding eath occurred at the time, investigation, in my opinion	e given in Part ace of Death (0 Other injury at Work? Yes 2 X t e building, etc. date and plaction, death occurses number C.M.E.	23e. Did 1 Yes 24a. Wa aut per 1 Yes Check only one) Nursing Home 5 28d. Describ No Unk 28f. Location or Town 18700 Wa te, and due to the caurred at the time, da	tobacco use es 2 No s an opsy formed? 2 No Residence e how injury of (Street and I State) alkers (use(s) and m the and place, 29d. Date	contribute to contribute to 3 Prot 24b. Were at prior to a death? 1 Ye 6 Othe Coccurred Number or Ru Anner as stat and due to the e signed (Mo	the cause of death? bably 4 Unknown utopsy findings available completion of cause of es 2 No r: ural Route Number, City d, Caithersbury ted. he cause(s)	
To the Hospital or Attending Physician: The law requires that the death certificate be exe within 24 hours after death. To the Funeral Directors. The this certificate has been signed by the attending physician a completely filled in by the funeral director, page 2 should be detached for use as the burial.	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkno Part II. Other significant condition 25. Was case referred to medical examiner? 1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investig 3 Suicide 6 X Could in determited to the condition of	AMENDED 1, 2. 23c. If yes, outcor 1 Live birth 4 Pregnant at 9 Unknown 1s contributing to deat 28a. Date of Inju (Month, Day, V) 3/21/08 28e. Place of Ir (Specify) Apar 3/21/08 28e. Place of Ir (Specify) Apar 3/21/08 28e. Place of Ir (Specify) Apar 3/21/08 28e. Place of Ir (Specify) Apar 3/21/08 28e. Place of Ir (Specify) Apar 3/21/08 29 Apar 3/21/08 20 Completed cause of completed cause o	ent 2 ER/C Injury - At home, interest But how when the summation and/or death (Item 23a)	26.Pia Dutpatient 3 DOA Time of Injury 28c. Ir 32p farm, street, factory, officilding eath occurred at the time, investigation, in my opinion	e given in Part ace of Death (0 Other injury at Work? Yes 2 X t e building, etc. date and plaction, death occurses number C.M.E.	23e. Did 1 Yes 24a. Wa aut per 1 Yes Check only one) Nursing Home 5 28d. Describ No Unk 28f. Location or Town 18700 Wa te, and due to the caurred at the time, da	tobacco use es 2 No s an opsy formed? 2 No Residence e how injury of (Street and I State) alkers (use(s) and m the and place, 29d. Date	contribute to contribute to 3 Prot 24b. Were at prior to a death? 1 Ye 6 Othe Coccurred Number or Ru Anner as stat and due to the e signed (Mo	the cause of death? bably 4 Unknown utopsy findings available completion of cause of es 2 No r: ural Route Number, City d, Caithersbury ted. he cause(s)	

State

Registrar

ddress of pe

31. Date filed (Month, Day, Year)

completed cause of death (Ite

Registrar's Sign

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Maryla		artment of F rtificate of			ene200	8 10317
	Physici	an	Decedent's Name (First, Middle, La Franciska Von V					2. Date of Death Month	Day Yea	3. Time of Death 3:50 P. M
	/Medic Examin		4a. Facility Name (If not institution, giv Washington Advent			4b. City, Town, o	r Location of Death	March 1	1, 2008 4c. County of D Montgo	
4	Funeral Director		5. Social Security Number 6. S		rs. last birthday) 7 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, OCt. 1,		Birthplace (State or Foreign Country) 1stria
D D		'n	Usual Residence of Decedent 10a. State 10b. County Maryland Montgome		City, Town or Lo					10d. Inside City Limits 1X Yes 2 □ No
with the M 3a or 28a-f st be notifie	al Director	10e. Street and Number 734 Silver Spring			10f. Zip Code 20910			og. Citizen of What United S		
036	be filed within 72 hours after death with the Maryland tial Hyglene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🔀 No	lispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- pecify Yes or No- No- No- No- No- No- No- No- No- No-		merican Indian, /hite, etc. White
9500-6121	filed within 72 ho Hygiene. ther than "natur int, the Medical Is	Completed	15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired ICE Manac	during most of wori ਹ)	king	16b. Kind of Busine Embassy	ess/Industry
yland 2	ild be filed v lental Hygie ked other t fc event, th	To Be Co	17. Father's Name (First, Middle, Last Julius Neumann)	022		18. Mother's Nam	ne (First, Middle, M Ratzersdo		
Mar	s 1 and 2 should be f Health and Mental tem 27 is marked other traumatic ev	_	19a. Informant's Name/Relationship (Antonia Bryk/ Dau	ghter	734 \$	Silver Sp	and Number or Ru pring Aver	nue Silve		,MD 20910
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State G	eorgeto Medical	^{matory} or other pla wn Univer center		ch 12 08	Washingto	on, D.C.
g	permi Depar Impor any ir		21. Signature of Funeral Service Lice	Stenden	9	013 Annap	polis Roa	d, Lanhai	n, MD 207	
	Physician		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	iplications that caused the de- one cause on each line.	eath. Do not ent	ter the mode of dyi	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	/Medical Examiner	er	Sequentially list conditions,	b. Due to (or as a cons	Porte	monja				8 Days
58760,	icate be executed physician and s the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C Due to (or as a consequence of):							
O. Box 68	The law requires that the death certifica the has been signed by the attending of page 2 should be detached for use as it.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome pf pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	□Ectopic pregnanc	у		23d. Date of Month	delivery Day Year
7	equires that en signed b suld be deta	by	Part II. Other significant conditions	contributing to death but not r	resulting in the u	anderlying cause giv	ven in Part I.	23e. Did tol	10.0	te to the cause of death? Probably 4 □Unknown
al Records,	The lar	Completed						24a. Was a autops perform	y prior	
. VIII	Physiclan: rthis certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2	ER/Outpatie	nt 3 DOA Oth	ner.	ith <i>(Check only on</i> fome 5 ☐ Reside		Specify)
ion or	anding Physath. or: After this ore funeral dir	ation: T	27. Manner of Peath 1 Natural 5 Pending 2 Accident investigation		ry at rk? ∣Yes 2 □ No	sing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred				
DIVISION	To the Hospital or Attending Promitin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	building, etc. (Spe	ecify)			City or Town	n, State)	or Rural Route Number,
	he Hosp n 24 hou he Fune pletely fil	Medical		hysician: To the best of my l miner: On the basis of exam and manner stated.						
)	To t Within	M	29b. Signature and title of certifier	- John	D-0.	29c. Licen:	- 0	8	9d. Date signed (A	Nonth, Day, Year)
	w		30. Name and address of person who ASHISH TOLIA	00, 7600 CAN	RROLL !	Print) WENUE,	TAKO	MA PAR	K, MC	20912
	Sta	ate	31. Date filed (Month, Day, Year)	32. Jegistrar's Si	gnature	Cartte B			1	

)8-02296 Villiam Charles \	Nel	Please Type or Print in Black Indelible Indelible Indelible Indelibre State of Maryland / Department or				0.5			
Physicia	1	1- For State Registrar 1. Decedent's Name (First, Middle,Last)				. No. 200	3. Time of Death		
Medical Examin					Month I March 23, 2	Day Year 2008	1335 hrs		
		4a. Facility Name (if not institution, give street and number) University Hospital	4b. City, Town, or Location of Death Baltimore 4c. County of Death						
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Ye Months Da		_		thplace (State or Foreign untry)		
Director	L	220-82-2941 1 X M 2 F 40 Yrs		170010	Sept. 1	7,1967 Mar	yland		
v any	Ī	10a. State 10b. County 10c. City, Town or Locat					10d. Inside City Limits		
·land -f sho		Virginia Berkley County Martinsbur			1	g. Citizen of What Cou	1 Yes 2 X No		
or 28a	.≘	10e. Street and Number	10f. Zip Code 25403			U.S.A.	nuyr		
	la		as Decedent of H	lispanic Origin? (§	Specify Yes or No-	14. Race - Amer	ican Indian, Black,		
death or item	Funeral	1 Never Married 2 X Married Armed Forces? If Y		an, Mexican, Puert	o Rican, etc.)	White, etc.			
s after ral", o		3 Widowed 4 Divorced If Yes, Give Year or Dates:		lo specify: ation (Give kind of	Lucul dono	Specify: Whi			
2 hour	ted.			fe. DO NOT use re		Tob. Nina of Business/	industry		
036 ithin 7 ane. r than	Completed by	12 Pressm	nan			Printing C	ompany		
15-0 filed w I Hygin of other		17. Father's Name (First, Middle, Last)		lt .	ne (First, Middle, Ma E.Shrade				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		William R. Weller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailin	g Address (Stre			er, City or Town, State	e, Zip Code)		
MD nd 2 sho alth and m 27 is					insburg,				
nore, ages I and nt of Heal nt: If iten other tra		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition crematory or ot		emetery,	Date	20c. Location - City or	Town, State		
Baltimore, permit. Pages I an Department of Hea Important: If iter injury or other tr.	ļ	4 Donation 5 Other Specify: Rest Have	n Cemet				, Maryland		
Balt permit Depart Impor	1					Fiery Fun Jagerstown,			
Physician	7	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.					Approximate Interval Between Onset and		
/Medical xaminer		Immediate Cause (Final disease a. <u>Head Injuries</u>					Death		
		or condition resulting in death) Due to (or as a consequence of):							
	<u>ne</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Cause. Enter Underlying Cause							
ء دارر	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):							
xecu n and	둉	d. X UNPENDED AMENDED 23a, 27, 28a-f per M	1F 0878 /1/	78/08 amb					
760, ficate be exe g physician i	Jed j	IF FEMALE: 23c. If yes, outcome of pregnancy	ш go/o 4/	20,00 200		23d. Date of deliver	<u></u>		
OX 687(eath certifica	ian/	23b. Was decedent pregnant in the past 12 months?	etal death 3	Ectopic pregi	nancy		Day Year		
Box 68760, e death certificate be the attending physic ef for use as the buri	Physician/Medi	1 Yes 2 No 9 Unknown Pregnant at time of death 5 O	ther (Specify)			X.			
detr	ğ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause	e given in Part I.		2 No 3 Pro	the cause of death?		
ords, w require	Completed				24a. Was a		utopsy findings available		
ecor he law te has l	ᇤ				autops perforr 1 ✓ Yes 2	med? death?	completion of cause of es 2 No		
Vital Rec ysician: The l his certificate l director, page	Bec	25. Was case referred to medical	26.Pla	ce of Death (Chec					
Vita	리	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpatien				Residence 6 Other	er:		
in of ding Ph. h. : After t	ë	27. Manner of Death 28a. Date of Injury (Month, Day,Year) Natural 5 Pending E 1 2 / 22 / 20 Pending T 1 2 / 22 / 22 / 22 / 22 / 22 / 22 / 2	1	njury at Work?		ow injury occurred			
Visior or Attend fler death Director: in by the	licat	2 X Accident Investigation Fnd 3/23/08 Fnd 2:00		e building, etc.		treet and Number or R	ural Route Number, City		
Div pital o ours afi	Certification:	Suicide 6 Could not be determined (Specify) House			or Town, St.	^{ate)} mac St.,Hage	rstown,MD		
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occu							
To the within 2 To the Complet	Medical	and manner stated. 29b. Signature and title of certifier		nse number	1	29d. Date signed (M			
		Pamily rethered MI)	0.0	C.M.E.		March 24, 2008			
		30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 11	I1 Dann Stra	et, Baltimore,	MD 21201				
St	ate	A A		et, Daniinore,	VID Z IZU I				
Regist	rar								

08-02296

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 2008 ear Malcom Womack 8, 4:31 PM March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Laurel George's Laurel Regional Hospital Prince If Under 24 Hrs. 8. Date of Birth 9. Birthplace (S Country) s last hirthday **Funeral** Months Days Hours 1**X** M 2□ F 07/09/1939 Yrs 224-58-0907 68 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pittsylvania Java 1 ☐ Yes X☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 450 McDaniel Road 24565 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ★ Married 1 ☐ Yes 2 No Spellack ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Unknown 7th Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Womack Edna Barksdale 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Bertha Womack/Wife 450 McDaniel Road Java Virginia 24565 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 03-15-08 Halifax, VA 4 Donation 5 Dother (Specify) CountyLine Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dunn&Sons 5635 Eads St. NE 2 0019 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hypertensive Cardiovascular Disease /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to for as a consequence of Examine cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Chronic Renal Failure Completed Metastatic Carcinoma of Prostate 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an Seizure , Diabetes 1∐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Minpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 ☐ DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 physician attending p by certificate this

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

ral", or items 23a or 28a-f show Examiner must be notified at

'natural', or

is marked o

the Hospital or Attending Physician: hin 24 hours after death.

31. Date filed (Month, Day, Year) MAR 1 8 2008 Registrar

4 Homicide

(Check only

29b. Signature and title of certifier

29a. Certifier

Medical

R.G. Bhojraj MD 704 Gorman Ave #T-1 Laurel, MD 704 __ 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D23181

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

03/10/2008

20707

Examiner The law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760 ed by the attending physician detached for use as the buris has the Hospital or Attending Physician: After after death within 24 hours a

Baltimore, Maryland 21215-0036

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 **1**√√0 ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Anatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 1 M' 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Runerdal aadia M.D Husain MD 2073 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 1 8 2008

State Registrar

4b. City, Town, or Location of Death

<u>Thurmont</u>

2. Date of Death Month

March 14,

2008

Frederick

4c. County of Death

4:30 P M

Baltimore, Maryland 21215-0036		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	Examir
To Be Completed by Funeral Director		ner

Physician

/Medical

1. Decedent's Name (First, Middle, Last)

Raymond William Walker, Jr.

13329 Catoctin Furnace Road

4a. Facility Name (If not institution, give street and number)

Physician /Medical **Examiner**

The law requires that the death certificate be executed physician and s the burial-trans as the signed by the has certificate has rector, page 2 or Attending Physician: this (after death.

| Director: /

Division or Vital Records, P.O. Box 68760.

If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex Days 1 X M 2 □ F 65 Dec. 17 217-42-2787 1942 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2X No Directo Maryland Frederick Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21788 13329 Catoctin Furnace Road United States Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2XXMamied 1 ☐ Yes 2 ☒ No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Assistant Manager Grocerv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond William Walker, Sr. Helen Virginia Duvall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 21788 19a. Informant's Name/Relationship (Type. Print) Amelia Walker / Wife 13329 Catoctin Furnace Rd. Thurmont, MD 20b. Place of Disposition (Name of competery, gramatory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Marchate 18. 1 Surial 2 □ Cremation 3 □ Removal from State 2008 Frederick, Maryland 4 □ Donation 5 □ Other (Specify) Memorial Gardens 21. Signature of Funefal Service Licensee Resthaven Fulleral Services, Skkot Cody PA 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 bromplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter if e disease, sheck, or lart failure. Immediate Chuse (Final Extensive Recurrent Lung Cancer 3 yrs. disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if a pr. leading to hime flat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lor as a consequence of Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Vear in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Was a... autopsy performed? Yes 2 12 No 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 □ ER/Outpatient 3 □ DOA P 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 X Natural Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 152 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 14626 March 17, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 501 West 7th St. Frederick, MD 21701 Gregory P. Rausch, M.D.32. Registras Signature 31. Date filed (Month, Day, Year)

State

Registrar

Fo the within 24 hours ...
To the Funeral Directory of the Funeral Director of the Funeral Directory of the Funeral Directory of the Funeral Directory of the Funeral Directory of the Funeral Directory of the Funeral Directory of the Funeral Directory of the Funeral Directory of the Funeral Directory of the Funeral Directory of the Funeral Directory of the Funeral Directory of the Funeral Directory of the Funeral Directory of the Funeral Directory of the Funeral Directory of the Funeral Directory of the Funeral Director of the Funeral Directory of the Funeral Direct

1 8 2¢08 b

within 24 hours after death To the Funeral Director:

Sequentially list cond if any, leading to main cause. Enter Underly Cause (Disease or inj	ediate 👅	b. Due to (or as a conseq					
that initiated events resulting in death) Las		cDue to (or as a conseq	juence of):				
IF FEMALE: 23b. Was decedent p in the past 12 m 1 yes 2 1 yes 10 yes 2 1 yes 2 1 yes 10 yes 2 1 yes 10 yes 2 1 yes 10 yes 2 1	onths?	23c. If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o 9 ☐ Unknown	al death 3 □Ectopic			23d. Date of delivery Month Day	Year
Part II. Other signific	ant conditions o	ontributing to death but not res	sulting in the underlying	g cause given in Part I.		o use contribute to the c 2 □ No 3 □ Probably	ause of death? 4 □Unknow
-					24a. Was an autopsy performed 1∐ Yes 2		
	d to medical			26. Place of De	eath Check onl one		
25. Was case referred examiner?		Hospital: 1 Inpatient 2]ER/Outpatient 3□	DOA Other: 4 Nursing	Home 5 ☐ Residence	e 6) AOther (Specify)	HOUSE
	5 ☐ Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred	
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, factify)	tory, office	28f. Location (Street City or Town, St	t and Number or Rural Ro tate)	ute Number,
27. Manner of Teath XNatural 2	7 rtifying Ph Medical Exan	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occurr ation and/or investigat	red at the time, date and plaction, in my opinion, death oc	ce, and due to the cause curred at the time, date	e(s) and manner as state and place, and due to the	d. e cause(s)
1	e of certifier	()0 0		29c. License number	29d	Date signed (Month, Day	Year)

Registrar DHMH 17 Rev 1/2001

State

Citl

CONNOR MD SOI W, SENERO

32. Registrar's Signature

30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print)

2008

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1 7 pay Month **Physician** Phyllis Louise 2008 Wroten March 9:30 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ruxton Health of Denton Denton Caroline | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Feb. | 8, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F 93 Yrs 218-24-7466 Maryland Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show Examiner must be notified at Preston 1 ☑ Yes 2 ☐ No Director MD Caroline 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 21655 3425 Linchester United States Funeral Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, items 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Examine 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X☐XNo Specify: White þ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seafood Seafood Processor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Riley Horseman Lavenia Gray Horseman ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 Sandy Hill Road, Cambridge, MD 21613 Donald Wm. Gray/Son 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Unity-Washington Cem. 03/22/08 |Hurlock, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licensee any ir CF5P 216 N. Main St., Federalsburg, MD 21632 23a. Part1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NEUMONIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): burial Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? FND-STAGE DEMENTIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【QUnknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No autopsy this certificate 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2NNo 1 Inpatient P 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death

To the Funeral Director:
completely filled in by the f 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BLOOMINGD ALE HUL 31. Date filed (Month, Day, Year) 2. Registrar's Signature State MAR 1 9 2008 Registrar

DHMH 17 Rev 1/200

K4

		•	1 - For Stata Registrar	State of Ma	ryland / Dep <i>Ce</i>	artmen ertificat					giene Reg. No.	008	3	10325
			1. Decedent's Name (First, Middle, Last)			-			2. Date of Dea Month	ath Day	Yea	ır	3. Time of Death
	Physici /Medio		BESSIE A. WI							MARCH		2008		12:14p ^M
1	Examir		4a. Facility Name (If not institution, give					Location			4c. (County of De		
			Chester River					erto		O Data of Bird	-	Ken		ice (State or Foreign
	Funeral		5. Social Security Number 6. Se	x 7.Age	(In yrs. last birthday 94 Yrs.	Months		Hours	Min.	8. Date of Birt (Month, Da Sept 1	Year)		Countr	land
	Director		217-30-8928 Usual Residence of Decedent		74					pept 1		/13 14	u.r.y	Land
	/land		10a. State 10b. County		10c. City, Town or I	ocation.				,			10	d. Inside City Limits
	Man Fish	ţ	MD Kent		Worton									1 Yes 2 XNo
	h the	irec	10e. Street and Number			10f. Zip	Code					en of What	Count	ry?
	23a c	alD	25090 Still Po	nd Neck			678					.A.		
920	ges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If item 27 is marked other than "natural", or itame 23a or 28a-f show or other traumatic event, the Medical Examinat must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Tyes 2 XN If Yes, Give Year or Dates:		Was Deced If Yes, spec 1 Yes		spanic Ori n, Mexicar Specify:		ecify Yes or No Rican, etc.)		4. Race - A Black, W Specify:		tc.
21215-0036	n 72 ho n maturi	Completed	15. Decedent's Ed (Specify only highest grad	le completed)	(Giv	edent's Usua e kind of wo DO NOT us	al Occupa rk done d se retired	ation luring mos	t of work	ing	16b. Kir	d of Busine	ss/Indu	ustry
12	2 should ba filed withln and Mental Hygiene. Is marked other than aumatic event, the Me	E	Elementary/Secondary (0-12)	College (1-4or 5	+)	estic					Self	emp	lov	ved
	Hygi other	BeC	17. Father's Name (First, Middle, Last)							e (First, Middle,				
lan	ould ba Mental Parked c	To B	Nathaniel Davis	5				Ida	Lev	wis				
Maryland	shot and N		19a. Informant's Name/Relationship (7							al Route Numbe				
	and 2 salth a n 27 ls		Ruth Thorpe (d	laughter									_	MD.2167
ore	of He fitem		20a. Method of Disposition 1 Burial 2 ACremation 3	Romoval from State	20b. Place of Disp cemetery, cr	oosition (Nar ematory or o	me of other plac			Date	20c. Lo	cation - City	or Tov	m, State
Ĕ	Pagnant mant: h		'4 □Donation 5 □ Other (Specify		Kent C					6/08		rna,	_	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tra 2009.		21. Signature of Fineral Service Cicen	X /	100510	Galen 118 W	a Address la F	s of Facili uner Cro	al I	Home o St. Ga	f St Iena	ephe , MD	n Į	Schae 1635
	Physician /Medical Examiner		23a. Pant. Enter the disease, or comp shock, or hear failure. List only of tmmediate Caus. Final disease or or as ion resulting in death)	aa. each lin	the death. Do not e.e.	nter the mod	de of dying	g, such as	cardiac	or respiratory a	rrest,			Approximate Interval Between Ooset and Death
30, <	be exacutad ician and burial-transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):									
8760,	ate be ex hysician the buria	dical	•	d									-	
P.O. Box 6	that the death certificate be tad by the attending physicis detached for use as the bur	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	□Ectopic p □ Other (sp					2	3d. Date of Month		y Day Year
	w requires that to be an signad by should be detail		Pan II. Other significant conditions co	entributing to death bu	ut not resulting in the	underlying o	cause givi	en in Part	1.		obacco u Yes 2[e to the	e cause of death?
ecol	4 2 5	Completed by	COPD							24a. Was	an psy rmed?	24b. Were prior deat	autop	sy findings available apletion of cause of
<u>=</u>	i e e	Sol								1 ☐ Yes	241 No			2 No
/ita	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Manager			Oth		e of Deat	h (Check only	one)			
£	Physician: this certific ral director,	ို	1 Yes 2 No	Hospital Inpatie				4 🗀 14		ome 5 Resi 28d. Describe			Specify)
Ē	ftai ne	ion	27. Manner of Death Natural 5 Pending	28a. Date of Injur (Month, Day	y Year) 28b. Time Injury	or M	28c. Injun Worl	yat k? Yes 2.⊑		200. Describe	now intur	y occurred		
Division of Vital Records,	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attal completaly filled in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ury - At home, farm, s c. (Specify)		-	163 2		28f. Location (City or To	Street and wn, State	d Number o	r Rural	Route Number,
	e Hospit 24 hour e Funera letaly fille	ledicai (29a. Certifier Check only one) Certifying Ph	ysician: To the best of the basis of and manner sta	examination and/or	ath occurred investigation	at the tin	ne, date a pinion, de	nd place, ath occur	and due to the red at the time,	cause(s) date and	and manne place, and	r as sta due to	ated. the cause(s)
	ro th within Fo th	₹	29b. Signature and title of certifier	7		29	c. Licens	e number			29d. Dat	e signed (M	lonth, [Day, Year)
			1600	C7 -	0	5	D1	64	0	00	3	126	/	06
	H		30. Name and address of person who of Wayne D. Benj	/			rch	Hil	l Ro	d. Ches	ster	town	, M	D. 21620
	St	ate	31. Date filed (Month, Day, Year)	32 Registra	ar's Signature	A								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / [Registrar	Department of Certificate of			iene2008	3 10326
	Physic /Medi		Decedent's Name (First, Middle, Last) CATHERINE WADE			2. Date of Death Month MARCH		3. Time of Death 4:00 a ^M
	Exami		4a. Facility Name (If not institution, give street and number) Chestertown Nursing & Rehab 5. Social Security Number 6. Sex 7. Age (In yrs. last bin	Chest	or Location of Death ertown	0 Date of Birth	4c. County of De	
	Director		260-46-4503 1□M 2⊠F 77 Usual Residence of Decedent 77	Yrs. Months Days		(Month, Day,	Year) 1931 Ge	irthplace (State or Foreign Country) Orgia
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or items 23a or 28a-f show any rigury or other traumatic event, Ita Medical Examinat. ust be notified at ance.	Director	10a. State 10b. County 10c. City, Town MD Kent Still 10e. Street and Number	n or Location Pond 10f. Zip Code		10	ng. Citizen of What C	10d. Inside City Limits 1 ☐ Yes 2 🔀 No
	death with ms 23a or	Funerai Di	13975 Still Pond Rd. 11. Marital Status 12. Was Decedent Ever in U.S.	2166	Hispanic Origin? (Sp	ecify Yes or No-	J.S.A.	
900	nours after ural', or ite	þ	Armed Forces? 1 Never Married 2 Married 1 Yes, Give Year or Dates:	If Yes, specify Cut	oan, Mexican, Puerto	Rican, etc.)	Black, Wh	_{ite, etc.} Thite
21215-0036	d within 72 h giene. Ir than "natu	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire Homemaker	during most of work ed)	ing	6b. Kind of Business Own Home	s/Industry
Maryland	nould be filed I Mental Hyg narked otha natic event,	To Be C	17. Father's Name (First, Middle, Last) Sam Vinson		Fannie	e (First, Middle, Ma Watkins	aiden Sumame)	
	is 1 and 2 st of Health and itam 27 Is n other traun		Dorothy Moore (daughter) 1 20a. Method of Disposition 20b. Place of	Mailing Address (Street 3975 Stil Disposition (Name of y, crematory or other pla	l Pond R	d. Stil		MD. 21667
Baltimore,	ermit. Page epartment on portant: If ny injury or 000.		'4 □ Donation 5 □ Other (Specify) Still 21. Signature of Puperal/Service Ucensee	Pond Cem	etery 3/		Staphon	ond, MD L. Schaec
	Physician		23a. Part. Enter the disease, or complications that caused the death. Do n shock, or he in failure. List only one cause on each line. Immediate Caus. (Final disease or con vion resulting in de. in)	ot enter the mode of dyi	Cross_S ng, such as cardiac	r respiratory arres	ena. MD.	21635 Approximate Interval Between Onset and Death
08/60,	flicate be executed Medical By Physician and Its the burial-transit	al Examiner	Sequentially list conditions, Fary, leading to finite date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or Due to (or Due t	v():				
	law requires that the death certificate as been signed by the attending physion? Should be detached for use as the total state as the total state.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death	3 ☐ Ectopic pregnanc: 5 ☐ Other (specify)	у		23d. Date of de Month	livery Day Year
oras, P	w requires that been signed b should be deta	ρ	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause giv	ren in Part I.	23e. Did toba	1	o the cause of death?
ב	The ate h page	Completed				24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
vision of vic	ng Phy Vier this	sation; To Be	2 Accident investigation	me of \$\frac{1}{28c}\$. Injur jury Wor	26. Place of Death er: 4 Nursing Hor y at 2 Yes 2 \[\] No	The second secon	ce 6 □Other (Spe	icity)
Ä	To tha Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	i Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farr building, etc. (Specify)			City or Town, S		
	o tha Hos vithin 24 ho o the Fun ompletely f	Medicai	29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, 2 Medicel Exeminer: On the basis of examination and and manner stated. 29b. Signature and title of certifier	death occurred at the tir or investigation, in my o	pinion, death occurre	ed at the time, date	se(s) and manner as and place, and due . Date signed (Mont	to the cause(s)
1	->-0		30. Name and address of person who completed cause of death (Item 23a) (T	Dog	41587		3/25/	2008
1	Stat Registra	е	Helen A. Noble, M.D. 122 Sp 31. Date filed (Month, Day, Year) 32. Registrar's Signature	eer Rd. C	hesterto	own, MD.	21620	
_	riegistic	"	MAR 3 1 2008 Reserve M	South 2				

DHMH 17 Rev 1/2001

1 - For State Registrar

			Decedent's Name (First, Middle, Last)					2. Date of Dea		UU	3. Time of Death
	Physici	an		שווכשווש	T ₄ J	TLHELM	SR.	Month 03	24 Day 20	Year CE	5.35 A M
	/Medic		WALTER	EUGENE	8.6	4b. City, Town, or		05 0	4c. County		
	Examir	ner	4a. Facility Name (If not institution, give street ar		1			3.0	,		ford
	19		3008 Whitefield R 5. Social Security Number 6. Sex	Oad. 7. Age (In yrs. last	hirthday)	If Under 1 Year	urchvil If Under 24 Hrs.	8. Date of Birt	h	9. Birtho	lace (State or Foreign
	Funeral Director		212-28-7169 1MM 2E		Yrs.	Months Days	Hours Min.	(Month, Da	y, Year) 931	Mar	yland
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Loc	ation				1	0d. Inside City Limits
	sho ed at	ō	MD. Harford			C	hurchvi	11e	1 □Yes 2 No		
	the N	Director	10e. Street and Number			10f. Zip Code	HIGH CITY I		10g. Citizen of	What Coul	ntry?
	with a or	ă	3008 Whitefield	Pood		· ·	21028		Unite	a st	ates
	s 23	era	1.2.11	Decedent Ever in U.S.	13. W			ecify Yes or No		ce - Americ	
	er de Item ner r	Funeral	Arm	ed Forces? Yes 2 ☐ No			spanic Origin? (Sp n, Mexican, Puerto	Rican, etc.)	Bla	ck, White,	etc.
36	rs aft r, or kami	by F	3 ☐ Widowed 4 ☐ Divorced Yea	s, Give Korea	1	Yes 2 No	Specify:		Specia	fy: W	hite
Maryland 21215-0036	be filed within 72 hours after death with the Maryland that Hyglene. dother than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	ed	15. Decedent's Education		6a. Deced	ent's Usual Occupa	ation		16b. Kind of B	susiness/In	dustry
5	in 72 1 "na Tedic	Completed	(Specify only highest grade compl		(Give F life. D	kind of work done o O NOT use retired	furing most of work)	ring			
7	with lene. thar	Ę	Elementary/Secondary (0-12) Coll	ege (1-4or 5+)		Owner	•		Ad	vert	ising
9	filed Hyg other		17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle,	Maiden Surna	me)	
an	Mental Mental arked c	To Be	Gorman	W	ilhe	lm	Mir	ıa		Sa	wyer
<u></u>	d 2 should be th and Mental 7 is marked of traumatic ev	-	19a. Informant's Name/Relationship (Type. Prin	t)	19b. Mailin	g Address (Street	and Number or Rui	ral Route Numb	er, City or Town	, State, Zij	Code)
Ma			Loretta A. Seguin	(Dau.)	924	Richwoo	d Court	; B	el Air	, MI	21014
	the second		20a. Method of Disposition	20h Plac	e of Dispos	sition (Name of natory or other place	na)	Date	20c. Location	- City or T	own, State
Baltimore,	0 0		1 Burial 2 □ Cremation 3 □ Removal 4 □ Donation 5 □ Other (Specify)	from State	•	Mem. G		7/08	Timoni	11m	Maryland
⋣	artme artme ortan Injur		21. Signature of Funeral Service Ligensee	uranev va	22.	Name and Address					ryland
Ba	permit. Pag Department Important: I any Injury o		VII Blackley 1	Lung in			0 0				e. P.A.
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus	that caused the death.	Do not ente	er the mode of dyin	g, such as cardiac	or respiratory a	rrest,	11011	Approximate Interval Between
В		Į,								-)	Onset and Death
1	Physician /Medical		disease or condition	ETASTATI		UNE CA	NCER.			-	3 MONTHS
100	Examiner			ue to (or as a consequer	ice oi).						
		<u>_</u>	Sequentially list conditions,	ue to (or as a consequer	nce of):						
\Box	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate Cause Einstein Lindright Cause (Disease or Injury that initiated events							3	
1	xecu and	xaı	resulting in death) Last	ue to (or as a consequer	nce of):						
9	be executed sician and burial-transit										
687	certificate be executed uding physician and use as the burial-transit	edic									
Box 68760,	ath certificate b ttending physic or use as the b	an/Medical	IF FEMALE: 23c. If ye 23c. If ye	es, outcome pf pregnanc	у)				ate of deliv	•
ă	death atter d for u	Cia	in the past 12 months?	Live birth 2 ☐ Fetal de Pregnant at time of deat		Other (specify)			N	fonth	Day Year
0	that the deat ned by the atte detached for	Physici	9 ☐ Unknown 9L	Unknown							
<u>ب</u>	s that		Part II. Other significant conditions contributing				en in Part I.	23e. Did	tobacco use co	ntribute to	the cause of death?
rds	w requires been signe should be	d by	CHRONIC OBSTRU	CTIVE PUL	MOST	ary Disc	ense.	1 🕹	¥es 2 □ No	3 ☐ Pro	bably 4 Unknown
00	w rec	lete	LOCULATED PLEUR	AL EFFUS	ION			24a. Was	an 24b	. Were aut	opsy findings available
Division or Vital Records,	The law requires that the dea tte has been signed by the at age 2 should be detached fo	Completed	METASTATIC LIVE	R MANCEL	3				ormed?	death?	2□No
a			25. Was case referred to medical		•		26. Place of Dea				
>	Physician: r this certific ral director,	To Be	examiner? 1 Yes 2 No Hospital	1 ☐ Inpatient 2 ☐ EP	₹/Outpatien	t 3 DOA Oth	er: 4 ☐ Nursing H	ome 5 Res	idence 6 □O	ther (Spec	ify)
ō	g Physer this eral di				8b. Time of	28c. Injui Wor	y at	28d. Describe	how injury occu	urred	
on	th. : After	ţi	1 ☑∕Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		Yes 2 □ No	_			
/isi	or Attending ifter death. Director: After in by the fune	fica	E	Place of injury - At home building, etc. (Specify)	e, farm, str	eet, factory, office			(Street and Nun	nber or Ru	ral Route Number,
ă	after after din h	Certification:	4 _ Horricide	building, etc. (Specify))	ony or re			
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier 1 CertifyIng Physician: 2 Medical Examiner: Or	To the best of my knowled	edge, death	occurred at the ti	me, date and place	e, and due to the	cause(s) and r	manner as	stated.
	n 24 n 24 ne Ft	Medical	(Check only 2 ☐ Medical Examiner: Or one) an	d manner stated.	ii and/or iii						
	To the within To the Com	Ž	29b. Signature and title of certifier	M.D. ATTENDO		29c. Licens			29d. Date sign	- 1	
L				PHYSIC	IAN	Do	21207		03/2	4/ 34	50 g
-	141		30. Name and address of person who complete		3а) (Туре,	Print)	752			,00.	
	Hy.		FRANZ C. VELLA-C			TID CREST	CT. BA	LTIMORE	MD 2	1286	
		ate	31. Date filed (Month; Day, Year)	32. Registrar's Signatur	re						
	Regist	rar	MAR 3 1 2008	Mayer	K A	1000					
DH	IMH 17 Rev 1/2	2001				-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. ∠ 2. Date of Death 1. Decedent's Name (First, Middle, Last) ALEXANDER MARCH **Physician** 12:26AM 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE AGNES HOSPI TAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)

Nary and 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1.2M 2□ F Yrs Director 11 ans Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Exa<u>miner must be notified at</u> 1 Yes 2 No M **Funeral Director** more 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? eine 122 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ZNo Baltimore, Maryland 21215-0036 Specify: ģ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) HUTELS aborer 300 Department of Health and Mental Hygie Important: If item 27 Is marked other i any injury or other traumatic event, tt once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MIRI 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bacto. Kellam mable 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 ☐Removal from State 5-08 Zion Com 4 □ Donation 5 □ Other (Specify) Pass 21. Signature of Funeral Service Licenses 22. Name and Address of Facility · march 23a. Pirt1. In if the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line.

Immediat cause (Final disease or condition Approximate Interval Between Onset and Death Immediat ause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4□Pregnant at time of death 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Donknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy 2VNo or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 3□ DOA Certification: To 1 Yes 2 No 2 ☐ ER/Outpatient After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury within 24 hours after deam.

To the Funeral Director: Af 1 🗌 Yes 2 Accident 6 Could not be determined 3 ☐ Suicide . Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c, License number P 2 2 2 5 3 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ATON AVENUE, 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State Registrar

DHMH 17 Rev 1/200

M.D., 7601 OSLER DRIVE,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BESSENT.

2008

32. Registrar's Signature

YHTOMIT 31. Date filed (Month, Day, Year)

APR 01

15452

08

21204

CIVA.

MARYL

TOWSON,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 03 **Physician** 28 08 0725 **Alley** James /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Allegany** WMHS Braddock Campus Cumberland Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Days 1 X M 2 □ F 245-10-2788 88 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show be notified at 10a. State 10b. County 1 ☐ Yes 2 No Director Hleganu umberla 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code than "natural", or items 23a the Medical Examiner must b treet by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 🗖 Divorced white Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Schmidt lesman permit. Pages 1 and 2 should be filed Department of Health and Mental Hygis Important: If Item 27 Is marked other any Injury or other traumatic event, the state of the state 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be : na Hie Myctle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemeter), crematory or other place)

Evans Fineral Chapel + 3/29/
Crematory Services Belance Shannon Stump-dowahte lowson mo Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Forest Hill Maryland 2008 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Evans Funeral Chapel & Cremation Services-Parky, 1/e Dar 8800 Harford Road Parkville mo 21234 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ACUTE RESPIRATORY **Physician** DITY /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed signed by the attending physician and ibe detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 1 🗍 Yes 3 Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 10 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2[[LN0 1 Depatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier i 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

29b. Signature and title of certifier

30. Name and address of per

31. Date filed (Month Pa)

Registrar DHMH 17 Rev 1/2001 DVERIA

who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

IR. MD 912 STOW DRIVE COMBAZIAND MD

MARCH 28, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	21	00	8		0	3	3
--	----	----	---	--	---	---	---

		1- For State Certificate of Death Reg. No.
Physicia	ın/	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year ORANGE OF THE PROPERTY OF THE PRO
Medical Examin	_	Chad Joseph Alvey 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
		223 Williams Rd. Ferndale Anne Arundel
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MW/DD/YYYY) 9. Birthplace (State or Foreign
Director		220-21-3220 12M 2 F 21 Yrs. Months Says Notes Months Months Says Notes Months Says Notes Months
any	}	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
8 1	١	MD Anne Arundel Pasadena 1 □ Yes 2 🗹 No
daryland 28a-f sho	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
h the N		7801 East Shore Road 21122 U.S.A.
Er death with the consistence of the constraint	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black, 15. White, etc. 14. Race - American Indian, Black, 15. White, etc.
// B D B hours after death with the Maryland ratural", or items 23a or 28a-f shi Examiner must be notified at once		3 Widowed 4 Divorced If Yes Give Year 1 Yes 2 ✓ No specify: White
ours a	ğ b	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
7 3 -	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)
215-0036 be filed within 72 ntal Hygiene. rked other than ent, the Medical	E O	12 Construction Worker Housing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	a	Gary Michael Alvey, Sr. Renee Colene LeMaster
D 21 should md Me is ma	은	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
and 2 shou lealth and I tem 27 is r traumatie	ł	Renee Alvey / Mother 7801 East Shore Road, Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State
Baltimore, permit. Pages I a Department of He Important: If ite		1 V Burial 2 Cremation 3 Removal from State crematory or other place)
Baltimore permit. Pages I Department of I Important; If injury or other	Ì	4 Donation 5 Other Specify: Glen Haven Mem Pk 03/25/08 Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility G.J. Gonce Funeral Home, PA
	4	169 Riviera Drive, Pasadena, MD 21122
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. List only one cause on each line. List only one cause on each line. List only one cause on each line.
kaminer		Immediate Cause (Final disease or condition resulting in death) a. Heroin and Methadone Intoxication Due to (or as a consequence of):
		Sequentially list conditions, b.
	Examiner	if any, leading to immediate Due to (or as a consequence of): couse. Enter Underlying Cause (Disease or injury that initiated
ted msit	Exal	events resulting in death) Last Due to (or as a consequence of):
760, icate be executed physician and the burial - transit	Medical	X UNPENDED
8760, ificate be ag physici s the buri.		IF FEMALE: 23b. Was decedent pregnant in the 23b. Was 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year
Box 68 e death certifi the attending ed for use as	icia	past 12 months? 4 Pregnant at time of death 5 Other (Specify)
that the death certificate by the attending detached for use as	Physician	Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
Division of Vital Records, P.O. Into Attending Physician: The law requires that the safter death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact		1 Yes 2 No 3 Probably 4 Vunknown
rds, requir been s	Completed by	24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of
eco he law tte has	E E	autopsy performed? prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
ian: T	Be C	25. Was case referred to medical 26.Place of Death (Check only one)
f Vit	P	1 Ves 2 No Trospital 1 Inpatient 2 ER/Outpatient 3 DOA Other: Scene
nding th.	ë	27. Manner of Death 28a. Date of Injury (Month, DayYear) 1 Natural 5 Pending Ted 3 / 21 / OP Ted 3 / 21 / OP Ted 3 / 21 / OP Ted 3 / 21 / OP Ted 3 / 21 / OP Ted 3 / 21 / OP Ted 3 / OP T
r Atter r Atter ter dear irector in by th	licat	2 Accident Investigation FIIC 3/21/05 FIIC 7:29 am UTIK 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City
Divis	Certification:	4 Homicide determined (Specify) Found on roadway 23 Williams Rd., Ferndale, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical (29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
F 3 F 8	₩.	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
		Tameet (withall ms) O.C.M.E. March 21, 2008
		30. Name and reference of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
Sta Regist		31. Date filed (Month, Day, Year) APR 0 1 2008 32. Registrar's Signature
DHMH 17 Rev 1/20		ORIGINAL
COLUE COCC		ON ON THE STATE OF

1. Decedent's Name (First, Middle, Last)

Social Security Number

Usual Residence of Decedent

10e. Street and Number

9006 Hines Road

218-18-9111

10a. State

Maryland

11. Marital Status

4a. Facility Name (If not institution, give street and number)

10b. County

FRANKLIN SQUARE HOSPITAL CENTER

Baltimore

1XM 2□ F

12. Was Decedent Ever in U.S. Armed Forces?

7. Age (In yrs. last birthday)

10c. City, Town or Location

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

Director

death with the Maryland

and 2 should be filed within 72 hours after death with naith and Mental Hygiene.

1.27 is marked other than "natural", or items 23a or er traumatic event, the Medical Examiner must be 1 Funeral 1 ☐ Never Married 2 ☐ Married 1 X Yes 2 □ No If Yes, Give Year or Dates: 1944-1944 White 1 ☐ Yes 2 💆 No Specify Be Completed by 3 ☐ Widowed 4 💆 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Shoe Repair Arcade Shoe Repair 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carrie M. Talmo Nazzarino Agostini 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9006 Hines Road Parkville, Maryland 21234 19a. Informant's Name/Relationship (Type. Print)
Mrs. Carrie Lewis - Daughter Department of Health Important: If item 27 any injury or other to once. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remoyal from State 4 ☐ Donation 5 🖒 Other (Specify) Entombment Gardens of Faith Cemetery (04-02-2008 Baltimore, Maryland 21. Signatur Juneral Service License 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ARTERIOSCEROTIC CORONARY ARTERY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leaving to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last One to (or as a consequence of) Examiner g physician and is the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9 I Inknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown been sign Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has l autopsy performed? certificate 2 000 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 X No ို 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 5 ☐ Pending investigation 1 Natural within 24 hours arten community to the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 121022 3-31-08 MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7602 BERAIN BACTO. MB. 21236 int wife 31. Date filed (Month, Day, Year) APR 0 1 2008 3 Registrar's Signature State Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Parkville

10f. Zip Code

4b. City, Town, or Location of Death

Rosedale If Under 1 Year | If Under 24 Hrs. 2. Date of Death

8. Date of Birth 10-16-1924 (ear)

3

Min.

21234

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

30

2008

Baltimore

U.S.A.

Black, White, etc.

14. Race - American Indian,

Maryland

4c. County of Death

10g. Citizen of What Country?

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits 1 ☐ Yes 2 XNo

2113 PM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, 4c. County of Death Examiner Alamed Ihe 3. Date of Birth (Month, Day, Year) (-24-193 9. Birthplace (State or Foreign **Funeral** Months 218-28 - 8081 Usual Residence of Decedent Director 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Examiner must be notified at 1 Yes 2 No Director Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 'naturai", or items 23a permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medion Examiner must any injury or other traumatic event, the Medion Examiner must once. Completed by Funeral Was Decedent Ever in U.S. Armed Forces? 11☑Yes 2☐ No If Xes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 💥 No Specify Specify: 3 Widowed 4 Vivorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Secondary (0-12) College (1-4or 5+) Bethleham Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) raigmont Rd, SISTER Marvis Barnes bodlaurumb 2/207 20a. Method of Disposition

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** pancreatic /Medical (or as a consequence of): **Examiner** patic Sequentially list conditions, if any, known to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician at the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) been signed by the s 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 TYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has b irector, page 2 s autopsy performed? 25. Was case referred edical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No this 27. Mann of Death funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the f Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

10

State

Schraeder

31. Date filed (Month, Day, Year)

APR 01

egistrar's Signature

Towson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year - 2008 **Physician** Tance /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner 9. Birthplace (State or Foreign **Funeral** Min. Months Hours 1 M 2 F Days Director 1ary/and 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 ⊈es 2 ☐ No Director timore 10e. Street and Number 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: \$ 3 ☐ Widowed 4 ☐ Divorced ack Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19a. Informant's Name/Relationship (Type. Pript) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2...
Department of Health ar
Important: If item 27 is
any injury or other trau Ralto. MD21207 irginial 20a. Method of Disposition

1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Place of Disposition (Name of cemetery, crematory or other place) 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** caranone 72372 108 disease or condition resulting in death) /Medical Due to or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of If any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-transi Due to (or as a consequence of) Box 68760; Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3/zzh8 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year signed by the a 1 Yes 2 No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 | Yes 2 | No 3 | Probably 4 | Jonknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 performed certificate acu 2 No Division or Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Hospital P 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours at er death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🖃 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 31. Date filed (Month, Day, Year) gistrar's Signature State APR 0 1 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 2:32 PM HOMAS MAR SE 2002 /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALT SAMARITAN HOSPITAL (-00) (MORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 X M 2□F Months Days Hours Director Nov 10, 1935 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Baltimore arkvill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 Funeral rrinah *Joods* 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 ☐ Never Married 2 N Married o 1 ☐ Yes 2 X No <u>></u> Specify 3 ☐ Widowed 4 ☐ Divorced 'natural", white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore than Elementary/Secondary (0-12) College (1-4or 5+) 12 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 catherine Lielinski ginski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is 2509 Perring Words

20b. Place of Disposition (Name of cemetery, crematory or other place)

Commetery Redeemer 4/3 Baginski Mary Bag 20a. Method of Disposition Koad arkville HD 21234 Date 1 Burial 2 ☐ Cremation 3 Removal from State 4/3/2008 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Evans Funeral Chapel + Cremation Services - Parkville
8800 Harford Road Parkville Maryland 21234 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myo Cardial Intace /Medical Due to (or a a consequence of): Examiner Stenosi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be execu Due to (or as a consequence of): Physician/Medical IF FFMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Dav 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ FAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes No 24a. Was an autopsy HEMODIALYUN Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Less Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical

29c. License number REJ - DOO

RAVEN

BLUD, BALTIMORE

Box 68760, Vital Records, To the Hospital or Attending Physician: within 24 hours a To the Funerai I

Baltimore, Maryland 21215-0036

APR 01 2008 Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

5601

32. Registrar's Signature

LOCH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 03 **Physician** BRYANI MIN STANDFORD /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chesapeake Hospice House Linthicum Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral Ø**M 2□F 349-24-5861 Illinois Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumattc event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Maryland Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1851 Hawk Court 21144 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1953
10 Yes 2 □ No 1798, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Military Police United States Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Coreen Evans Gus Bryant 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paula Bryant, Wife 1851 Hawk Court Severn, Maryland 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 03/31/08 Baltimore, Maryland ²² Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 21. Signature of Funeral Service Licensee Thomas Gregor Jamow 23a. Part1. Enter the disease, or complications that caused the delight. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Comar /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ned by the attending physician and detached for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ate has been sign page 2 should be 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 252 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hespel 1 Natural 5 Pending investigation itelly 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 124 hours at Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the 29b. Signature and title of certified

DHMH 17 Rev 1/2001

Registrar

IDYI

30, Name and address of person who

31. Date filed (Month, Day, Year)

Registrar's Signature

MGHWAY ANNAPOLIS MD MYOI

08-02434 Destiny Bailey Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

stiny Bailey	1. F	Sta or State	ate of Maryl	and / Depar	tment of ificate of	Health and Death	Mental H	ygiene Reg. N		08 1033
Dhysisian	Rec	istrar Decedent's Name (First, Middle	e,Last)					2. Date of Death	v Year	3. Time of Death 2242 hrs
Physician/ Examine	r 🗇	DESTINY	NIC	OLE	BAI	KEY		March 27, 200	08 4c. County of Deat	
	4a	Facility Name (if not institution	n, give street and r	number)	4	b. City, Town, or I		,	Worcester	
		Route 13 near Routes		T Ann /In ura los	et hidhday)			8. Date of Birth(M	IM/DD/YYYY) 9. B	inhplace (State or
Funeral	1	Booldi Goodini, Transcri	6. Sex	7. Age (In yrs. las		Months Days			1 010	ign country) VIRGINIA
Director		31-97-8458	1M 2XF	4	Yrs.			ZHROME;	17.0	
è	_	ual Residence of Decedent a. State 10b. County		10c. City, 7	Town or Locati	on				10d. Inside City Limits
_ s	~	HARYLAND WO	RCESTE	R PC	ocom	OKE	CITY			1 Yes 2 No
rylanc na-f sh	3 10	e. Street and Number				10f, Zip Code		10g.	Citizen of What Co	ountry?
eath with the Maryland items 23a or 28a-f show any ust be notified at once.		819 LYNNH	HAYEN	DRIVE		218	35/), S. A.	
with the same same same same same same same sam	<u>0</u> 1	. Marital Status	12. Was D	ecedent Ever in U.S	C 13 M/s	s Decedent of His es, specify Cubar	spanic Origin? (S	Specify Yes or No- o Rican, etc.)	14. Race - Amo White, etc.	erican Indian, Black,
Jeath r item	<u> </u> 1	Never Married 2 M	1 1 Yes	2 X No					Specify: B	LACK
after al", o	<u>ا ح</u>		vorced If Yes, Give Y			Yes 2 No		f work done 16	b. Kind of Busines	
hours af "natural Examin		15. Decedent's Education (Spe		e (1-4 or 5+)	during m	ost of working life	. DO NOT use re	etired)		
36 thin 72 te. than "	ompleted	Elementary/Secondary (0-12)	Concego	2(11010-7		NA			NA	
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica		7. Father's Name (First, Middle	e, Last)				18.Mother's Nan	ne (First, Middle, Mai	den Surname)	AILEY
215 e file tal Hy ked o	ag	UNKNOWN					DELIF	A ASHL		
D 21215-003 should be filed within and Mental Hygiene. 7 is marked other that natic event, the Med	_	9a. Informant's Name/Relation	ship (Type, Print)		19b. Mailir	ig Address (Stre	et and Number o	Rural Route Number	ch NRC IN	UP 23454
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f she reasonable to the Medical Examiner must be notified at once it has made and the Medical Examiner must be notified at once it has made and the made at the medical Examiner must be notified at once it has made at the medical Examiner must be not incorporate at the medical Examiner must be not incorporate at the medical manual	_	9a. Informant's Name/Relation		206	Place of Disno	sition (Name of C	emeterv.	Date	2001 2000	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "injury or other tranmatic even, the Medical	2	0a. Method of Disposition X Burial 2 Crematic	on 3 Remova	al from State	crematory or o	ther place)	k oo	2 2008	firginia Be	ach, VA
Page Page ment c		4 Donation 5 Other 4	apecity.	6.X			100			
Baltimore, permit. Pages I ar Department of He Important: If ite injury or other tr	2	1. Signature of Funeral Service	e Licensee	Olian.			TR 001 34	SR. FUN ENVE, BALT	DERAL HE	ME ID 21217
	-	3a. Part I. Enter the disease,	or complications the	at caused the death	n. Do not enter	the mode of dying	g, such as cardia	c or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
ysician Nedical	- 1	failure. List only one caus mmediate Cause (Final diseas	se on each line.							Death
Examiner		mmediate Cause (Final diseas or condition resulting in death)	Due to (or	as a consequence of	of):					
	.	Sequentially list conditions,	b	as a consequence of	of):					
	.드 1	if any, leading to immediate cause. Enter Underlying Caus	se c	as a consequence of	orj.					
/	Exam	(Disease or injury that initiated events resulting in death) Las		as a consequence	of):					
executed an and all - transit	ᆲ		d			-070 1 /4 //	20.52			
i	dical	UNPENDED		ED Item/20b,		G878,4/1/(18,WS		23d. Date of de	livery
76(ficate g phy s the b	Ž 2	IF FEMALE: 3b. Was decedent pregnant in		yes, outcome of pre ive birth		Fetal death	3 Ectopic pre	egnancy	Month	Day Year
Box 68760, e death certificate be the attending physic ed for use as the but	sician/Me	past 12 months?		regnant at time of d	death 5	Other (Specify)				
BO)	-	1 Yes 2 ✓ No 9 Vert II. Other significant con		Inknown	reculting in th	e underlying caus	e given in Part I.	23e. Did to	bacco use contribu	te to the cause of death?
VISION Of Vital Records, P.O. Box 68760, or Attending Physician: The law requires that the death certificate be after death. Director: After this certificate has been signed by the attending physici in by the funeral director, page 2 should be detached for use as the buril	by P	Part II. Other significant con	aitions contribut	ing to death but not	resulting in a	o 2.1.0011,	- 0	1 Yes	2 No 3	Probably 4 Unknown
Division of Vital Records, P.O. Ind or Attending Physician: The law requires that the safer death. "In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detaced.	<u>g</u>							24a. Was a		ere autopsy findings available or to completion of cause of
ord aw rec las bee	Completed							autop perfor	med? dea	ath? Yes 2 No
Rec The licate h	悥					26 PI	ace of Death (Ch		2 10 1	7 100
tal cian: certif ector,	Be	25. Was case referred to med examiner?	Hospital:	Inpatient 2	ER/Outpati		1-		Residence 6	Other: Scene
f Vi Physi er this	은	1 Yes 2 No 27. Manner of Death	28a.	Date of Injury	28b. Time		Injury at Work?	28d. Describe	now injury occurred struck by auto	1
nding th.: Aft	ë	1 Natural 5 P	rending	(Month, Day, Year) r 27, 2008	2232 hrs	1	Yes 2 V No	0		
ivision for Attend after death. Director:	icat		ould not be	. Place of Injury - At	t home, farm, s	treet, factory, offi	ce building, etc.			or Rural Route Number, City
Div ital or ral Di	Certification:	4 Denoicide	letermined (Sp	ecify) Roadway				Route 13 nea	r Routes 113 an	d 756, Pocomoke City, MD
Di the Hospital hin 24 hours a the Funeral	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state (Check only one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the									es stated. e to the cause(s)
Division of Vital Records, P.O. B rothe Hospiral or Attending Physician: The law requires that the de within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Medical		and mai	basis of examination nner stated.	n and/or inves		cense number		29d. Date signer	d (Month, Day, Year)
	ž	29b. Signature and title of ce	rtifier				.C.M.E.		March 28, 2	
		mi a	. »	~ J						
2		30. Name and address of per	rson who complete stant Medical	d cause of death (It	tem 23a) 11 Penn S	treet, Baltimo	re, MD 2120	1		
0			oorl E							
S Regis	tate	31. Date filed (Month, Day,Y		32. Registrar's Sign	600	42				

DHMH 17 Rev 1/2001

ORIGINAL

OCHAD

08-02435 **Delia Bailey** Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 | 0338

			For State			Certif	icate of i	Death				Re	g. No.		
Phys	icia		egistrar . Decedent's Name (First, Middl	e,Last)							2.	Date of Deat Month		'ear	3. Time of Death
	amin	_			414	13	AILE	-4				March 27,	2008	cai	2242 hrs
			a. Facility Name (if not institution	n give stree	HLY		41	o. City, To	wn, or Lo	ocation of I			4c. Coun	ty of Dea	th
		1	Route 13 near Routes				- 1	Pocom					Worce	ester	}
						e (In yrs. last	birth day ()	If Under	1 Veer	If Under	24Hrs	8 Date of Bir	th/MM/DD/YY	YY) 9. B	Birthplace (State or
Fune		- 1	5. Social Security Number	6. Sex			unday)	Months	_	Hours	Min.			Fore	eian
Direc	tor	3	124-49-9457	1M 2	2×F	20	Yrs.					SEPTEME	BER 28,19	81	Country) VIRGINIA
	_	h	Jsual Residence of Decedent												10d. Inside City Limits
	Ê	1	10a. State 10b. County			10c. City, To	wn or Location	on							1 1
	البه غ	_	MARYLAND WOR	CESTE	ER	Poc	omok	3.	CIT	4					1 X Yes 2 No
ylan	t ong	힀	10e. Street and Number					10f. Zip C	Code			1	0g. Citizen of	What Co	ountry?
Mar	e pa	ōΙ	AHUNYA PIBI	VEAL	DRIV	6		21	85	= /			0.3	. A.	
h the	s 23a or 25a-1 snow a e notified at once.						40.144				2 / Spe	cify Yes or No			erican Indian, Black,
n wit	Pe a	E	11. Marital Status 1 X Never Married 2 N		Was Deceden Armed Forces		If Ye	es, specify	Cuban,	Mexican, F	Puerto R	tican, etc.)		hite, etc.	
deat	nust	Funeral		1	Yes 2	≥ × No		5	~7				Cnaa	#. T	SLACK
after	L .	ğ		vorced If Yes	ates:			Yes 2					16b. Kind o		
Surs	ami mi	후	15. Decedent's Education (Spe	cify only hig	hest grade co	mpleted) 1	6a. Decedent	t's Usual C ost of work	occupations of the contract of	on (Give ki DO NOT u	ind of wo	ork aone ed)	Tob. Kind o	Dusines	shildustry
72 hc	, E	흥	Elementary/Secondary (0-12)	C	College (1-4 or	5+)	coming in								
336 thin	ed ic	림	IOTH GRADE				HO	me	MA	KER			1		OME
5-0036 fled within 7 Hygiene.	e e	Completed	17. Father's Name (First, Middle	, Last)					1				Maiden Surn		
215 be file ntal H	15. Ed	Be	LESSELL			BAILE	-4			PA:			_	DLI	
ID 21215-003 should be filed within and Mental Hygiene.	is marked other than itic event, the Medical	\sim Γ	10a Informant's Name/Relation	ship (Type, f	Print \		19b. Mailing	Address	(Street	and Numb	ber or R	ural Route Nu	mber, City or	Town, St	ate, Zip Code)
MD d 2 sho Ith and	7 is		LESSELL BA	71154	(FATE	HER)	1824	EGO	DI	RIVE,	YIRC	SINIA C	BEACH, V	11RG1	NIA 23454
of Health	If item 27 ner traum:	: I	20a. Method of Disposition			20b. Pl	oce of Dienos	ition (Nam	e of cerr	netery.		Date	20c. Local	ion - City	or Town, State
Baltimore, MD 21215-0036 sermit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.		- 1	20a. Method of Disposition 1 Burial 2 Crematic	n 3 R	temoval from S	State Ret.	ematory or oti	ner place)	Park	Too !	00011	3 200	Virgir	ria R	Fach VA
Baltimo permit. Page Department	or of		4 Donation 5 Utner	specify.		7270									
Balti permit. Departm	Import	- [21. Signature of Funeral Service	e Licensee	1	1.	22. N 50	Name and	Address	BROL	SN!	TR. FUI	VERAL	HO	ME
യ ജല്	트트		Dutics	-N. 1	Will	eam	1111	40 11.	1111	TIM	HVE	10111	millor CC.	1111	Approximate Interval
ysi	cian		23a. Part I. Enter the disease, of failure. List only one cause	or complication	ons that cause	ed the death. [Do not enter t	he mode o	ot dying,	such as ca	argiac or	respiratory a	nest, shock, t	n near	Between Onset and
	ical.	-	Immediate Cause (Final diseas	B. A. al.	tiple Injurie	es									Death
Exam	iner		or condition resulting in death)		to (or as a cor		:								
			Sequentially list conditions,	b											
		ē	if any, leading to immediate		to (or as a cor	nsequence of)	:								
		盲	cause. Enter Underlying Caus (Disease or Injury that initiated	G.											
/ _	·#	Examiner	events resulting in death) Las	Due	to (or as a cor	nsequence of)	:								
V ag	physician and the burial - transit			d											
e e k	cian rial	di Gi	UNPENDED	X AN	MENDED It	em//20b,c	perFH.	G878,4	4/1/0	B,WS					
760, icate be	shysi e bu	/Medical	IF FEMALE:		3c. If yes, outo	come of pregn	ancv							ate of del	ivery Day Year
687 certific	as th	an/	23b. Was decedent pregnant in past 12 months?	the 1	Live birth		=	etai death		Ectopic	c pregna	incy	Мо	nuı	Day Teal
Box 68'	the attending I	Physician	1 Yes 2 No 9 🗸 L	Inknown 4		at time of dea	th 5 0	ther (Spe	ecify)						
Box e death c	the a	hys		1 °			. Iv I- th-			sivon in Da	art I	23e Die	i tobacco use	contribut	te to the cause of death?
Records, P.O. I	signed by		Part II. Other significant con-	litions cor	ntributing to de	eath but not re	suiting in the	undenying	g cause	giveninira	ai t 1.				Probably 4 Unknown
⊡ . ∯	signe be d	d by										1			
of Vital Records, ng Physician: The law requir	ould	Completed										24a. W.	as an topsy		re autopsy findings available or to completion of cause of
IS S	has b	ďμ										pe	rformed? s 2 No	dea	ith? Yes 2 No
	cate	ĕ								45 11	(0):1		s ZINO	·	les 2 10
<u> </u>	certificate ector, page	Be (25. Was case referred to med examiner?							e of Death Other		-		0.7	Other: Scene
Vsice V	this	10 1	1 ✓ Yes 2 No	Hosp	oital: 1 Inp	atient 2	ER/Outpatie		DOA			ng Home 5			
of F	nera		27. Manner of Death		28a. Date of (Month, Date	Injury ay Year)	28b. Time of	f Injury		ry at Wor	_		be how injury in struck b		
C ig 4	or: A	[₽.	1 Natural 5 P	ending	Mar 27, 20	008	2232 hrs		1	Yes 2 ✓	No				
Division tal or Attendi	recto by t	Certification:	2 Accident In	vestigation	28e. Place o	of Injury - At ho	ome, farm, str	eet, factor	y, office	building, e	etc.	T	- Ctotal		or Rural Route Number, City
) i	al Di	Ĕ	3 Suicide 6 C	ould not be etermined	(Specify)	Roadwav						Route 13 r	n, State) lear Routes	113 and	756, Pocomoke City, MD
lospit	uner:	ပ္ခ်	4 Homicide 29a. Certifier	Dhuciaia	To the best s	of my knowled	ne death occ	urred at th	ne time.	iate and p	lace, an	d due to the o	ause(s) and r	nanner as	s stated.
Division of Vital F To the Hospital or Attending Physician:	To the Funeral Dir completely filled in	ledical	(Check only 1 Certifying one) 2 ✓ Medical E	, enysician: xaminer:Or	n the basis of	examination a	nd/or investig	ation, in m	ny opinio	n, death o	ccurred	at the time, d	ate and place	, and due	to the cause(s)
Total	Tot	ed	2 1 1101011	an	nd manner stat	ted				se numbe					(Month, Day, Year)
	Ĭ	Σ	29b. Signature and title of cer	1	^			12:					1	28, 20	
-			hish		me I				U.U	.M.E.			IVIAICI	. 20, 20	
2			30. Name and address of per	son who con	npleted cause	of death (Item	1 23a)								
1	,				lical Exami		Penn Str	eet, Bal	timore	, MD 21	201				
		tate	A DED V		27	istrar's Signati	ura A	rack							
	~		The state of the s	A LUC	A ARA	WILLAGE A		10 m							

			State of Maryland / Depar	tment of Health and Mo	ental Hygie	ene	
			1- State Amend #20a Per FH G878 4/01 908			. No. 2	10339
	Physici	an	Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year	3. Time of Death
	/Medic	al	Jean Martha 4a. Facility Name (If not institution, give street and number)	Bouldin 4b. City, Town, or Location of Death	3-29-	2008 4c. County of Deat	9:15 p
1	Examin	er	1328 Sherwood Avenue				.11
- 34	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		8. Date of Birth	N/A 9. Birt	hplace (State or Foreign
	Director		212-40-4446 1 1 M 2 F 66 Yrs.	Months Days Hours Min.	(Month, Day, Y 12-30-	-1941 Co	MD
	pu »		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local	ation			10d. Inside City Limits
	faryla show	ō					1 X Yes 2 No
	the N 28a-i	Director	MD N/A Baltimor	10f. Zip Code	100	. Citizen of What Co	ountry?
	3a or	Ē	1328 Sherwood Avenue	21239		USA	,
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. W. Armed Forces?	as Decedent of Hispanic Origin? (Spec Yes, specify Cuban, Mexican, Puerto F	cify Yes or No-	14. Race - Ame	
9	after or Ite	/Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	Yes 2 No Specify:	nicari, etc.)	Black, Whit	
21215-0036	hours ural"; il Exa	d by	3 Widowed 4 A Divorced Year or Dates:	••	The		Black
15-	n 72 n "nat ledios	Completed	(Specify only highest grade completed) (Give ki	nt's Usual Occupation ind of work done during most of workin D NOT use retired)	g	6b. Kind of Business/	,
712	withi	mo	Elementary/Secondary (0-12) College (1-4or 5+)	litor	l F	rederal	Government
פַ	be filed ntal Hygis od other event, tl	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Ma	aiden Surname)	
/lar	should by and Ments s marked umatic ev	To E	John Albert Bouldin	Susan Tu	cker		
Maryland	2 sho and is ma			Address (Street and Number or Rural		-	
, e	1 and 2 Health em 27 i			Sherwood Avenu			
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		20a. Method of Disposition → Burial 2XX remation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 20b. Place of Disposic cemetery, cremation Creenmon	1	ate 20	c. Location - City or	rown, State
量	nit. Partmel		7700			Balto, Mi	D
Ba	permit. Departm Importar any Injur		# 6 a d - 4 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	1101 E. North	rch F/E		21202
			23a. Part1. Enter the disease, or implications that caused the death. Do not enter				Approximate Interval Between
Ų.	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	hartama			Onset and Death
F	/Medical		resulting in death) a. Due to (or as a consequence of):	COOLOGO			11
Š.	Examiner		Sequentially list conditions. b. Poleast Ca	2			17 years
7	ed sit	Examiner	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury				
· .	cate be executed ohysician and the burial-transit	хап	that initiated events resulting in death) Last C				
8760,	sician burit	dical E					
9	ifficate g phy as the	edic	0.				
Вох	The law requires that the death certific. It has been signed by the attending place 2 should be detached for use as to	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 3 □E	Ectopic pregnancy		23d. Date of de	
	e deal	sicia	1 Yes 2 No 4 Pregnant at time of death 5 0	Other (specify)		Month	Day Year
P.O.	w requires that the d been signed by the should be detached	Phy	9 Li Unknown	leshing gaves given in Dort I	22a Did taha	non una anntributa t	o the cause of death?
ds,	ires the signe	þ	Part II. Other significant conditions contributing to death but not resulting in the und	enying cause given in Fait i.	1 ☐ Yes	1	robably 4 □Unknown
or Vital Record	v requ	Completed					
Be	he lav e has ige 2	dm			24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
ta	ician: Th certificate ector, pag		25. Was case referred to medical	26. Place of Death		No 1 □ Yes	2 □ No
<u> </u>	Attending Physician: r death. ector: After this certific by the funeral director,	To Be	examiner? 1 Yes 2 Hospital: 1 Inpatient 2 ER/Outpatient	Othor		ce 6 □Other (Spe	ecify)
0	ng Ph fter th neral		27. Manner of Death 28a. Date of Injury 28b. Time of Injury (Month, Day Year) 28b. Time of Injury		8d. Describe how		
Sio	Attendle death. ctor: A y the fu	atic	2 Accident investigation	M 1 Yes 2 No			
Division	l or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, stree building, etc. (Specify)	t, factory, office 2	8f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
	Hospital 24 hours a Funeral C		29a. Certifier 12 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place is	and due to the car	ISO(s) and manner a	e stated
		edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or invegored and manner stated.				
	To the within To the Comple	Me	29b. Signature and title of gertifier Of . Columbia	D 29c. License number	290	d. Date signed (Mont	th, Day, Year)
) realist in the state of	141406		3/31/	08
	5		30. Name and address of person who completed cause of death (Item 23a),(Type, P	" N charles	Sireoz		
				Baitmore	ND	21204	
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature				
DU	MU 17 Pay 1/9/	- 1	APR 0 1 2008 Moreur 18 1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Estella Mae Browne 2008 03 30 1:00a.M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Loving Touch Assited Living Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Min. 1 □ M 2 🛛 F 218-12-0929 MD 92 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits M☐Yes 2☐No Baltimore NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 U.S.A. 2229 Southland Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Tes 2 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify Black 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Dietician 10th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Annie Mondowney Harry Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8033 Montwood Road, Baltimore, Md 21244 Marguerite Brown-Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 20c. Location - City or Town, State N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, Md 4/4/08 Crownsville Vet 22. Name and Address of Facility 21. Signature of Funeral Service Licenses March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Mocaeha resulting in death) Due to (or as a consequence of): ronz Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): c.hm Due to (or as a consequence of):

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

Completed by

ည

MD

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed

Examiner

Physician/Medical

þ

Be Completed

Certification: To

and use for pe this After t within 24 hours after deal

Division or Vital Records, P.O. Box 68760,

or Attending Physician:

Hospital

				\ I							1		
IF FEMALE: 23b. Was decedent pregint the past 12 month 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	riani	1 🗆 4 🗆	s, outcome pf pregna Live birth 2 Feta Pregnant at time of d Unknown	al death 3 □E						23d. Date of d Month	elivery Day	Year	
Part II. Other significant	conditions co	ontributing	g to death but not res	ulting in the unde	erlying	caus	e given in Part I.		23e. Did tobacco u		robably	se of death?	
									24a. Was an autopsy performed? 1☐ Yes 2☑ No	prior to death?	completio	idings available on of cause of lo	
25. Was case referred to	medical						26. Place of Dea	th (C	heck only one)	•			
examiner? 1 ☐ Yes 2 No		Hospital:	1 Inpatient 2	ER/Outpatient	3 🗆 1	OOA	Other: 4 Nursing H	lome	5 Residence	6 Nother (Sp	ecify)	ssisted	
2 Accident	Pending investigation		Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c.	Injury at Work? 1 ☐ Yes 2 ☐ No	28d	. Describe how injur		í.	sult 5	
3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	28e.	Place of injury - At he building, etc. (Specif	ome, farm, street y)	t, facto	ory, of	fice	28f.	Location (Street an City or Town, State		Rural Rout	e Number,	
29a. Certifier 1 1 (Check only 2	Certifying Phy Wedical Exam	ysician: Tiner: On	To the best of my kno the basis of examina	owledge, death o ation and/or inves	ccurre	ed at t	he time, date and place my opinion, death occu	and urred	I due to the cause(s) at the time, date and	and manner and di	as stated. Le to the c	ause(s)	

00061439

2600 LIBERTY

29d. Date signed (Month, Day, Year)

03, 31, 2008

Registrar

31. Date filed (Month, Day, Year) APR 01 2008

29b. Signature and title of certifier

SUSANYA

C+CMISI 32 Registrar's Signature

30. Name and address of person who complifed or use of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 25 Year **Physician** Blackwell, Richard March 2008 18:57 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore The Johns Hopkins Hospital City 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) 7. 30 - 1953 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F Months | Days 218-58-708 54 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Martal Hyglens. Institutely of items 23a or 28a-1 show Important: It Item 77 is marked other than "natural" or items 23a or 28a-1 show any Injury or other traumatic event, the Medical Examiner must be notified at 1 √res 2 No Baltimore MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21231 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No R þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Father's Name (First_Middle, Last) 's Name (First, Middle, Maiden 19a, Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) C. East Baltimore St. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore, and 1.08 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 5 days Renal Failure /Medical Due to (or as a consequence of): Examiner Hepatoencephalopathy Sequentially list conditions, if any, searing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of) Examiner requires that the death certificate be executed Cimhosis Due to (or as a consequence of): physician a s the burial-1 Box 68760, Physician/Medical as attending IF FEMALE for use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.0. ed by the a detached f 9□Unknown 9 Unknown has been signed by ge 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 Tes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1□ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page within 24 hours after death.

To the Funeral Director: After this certificate to completely filled in by the funeral director, page Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 Minpatient 2 ER/Outpatient 3 DOA ۴ 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: or Attending Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) brelyn Kim Medizal Ductor March 25, 2008 Res- 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joselyn Kim. The Johns Hopkins Hospital, 600 North Welfe Street, Baltimore Maryland 21287 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

APR 01

2008

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-02437 2008 State of Maryland / Department of Health and Mental Hygiene Cherise Bowie 1- For State amend #20b Per FH G8784/9911/68/e.mf Death 2. Date of Death Time of Death Decedent's Name (First, Middle,Last) Physician/ March 28, 2008 0515 hrs Bowie Modical Examiner nerise 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Maryland General Hospital Baltimore If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Min. Months Days Hours Country) MD 04 Director 219-86-8517 2 V F 1 M Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No NIA Baltimore "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at once. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number otherne USA 4627 21229 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 2 No Yes Specify: Black Yes 2 No specify: more, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours after near of Health and Mental Hygiene. Divorced f Yes, Give Year Widowed \$ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Flementary/Secondary (0-12) Jurse Oth t: If item 27 is marked other other traumatic event, he Me 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bowle can Be (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address Balto. Mb. Baltimore, MD Colherne Ka Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 4/0472008 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State Baltu MD. Par tant: Donation 5 Other Specify Name and Address of Facility
Volumen C-Greene
515 Bactimore J 21. Signature of Funeral Service Licenses Funeral Services MD. 21229 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line Madica Death a Cirrhosis of liver Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last pue Physician/Medical #MENDED 7, perME, g879 5/14/08 TT X UNPENDED attending physician or use as the burial law requires that the death certificate be Box 68760 23d. Date of delivery IF FFMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 V Unknown Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. ğ 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed? ✓ Yes 2 1 🗸 Yes this certificate 26.Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 ✔ Inpatient 2 examiner? Other₄ Nursing Home 5 Residence 6 Other DOA ER/Outpatient 3 1 🗸 Yes ٩ 28c. Injury at Work 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After 27. Manner of Death Certification: 1 X Natural Yes 2 No Pending To the Funeral Director: 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 29, 2008 O.C.M.E. WO 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Mediçal Examiner Margarita Korell MD 31. Date filed (Month Day Y istrar's Signature Year State 200 Registrar OCIVIE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Fred Douglas Brown State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day March 28, 2008 0945 hrs **Medical Examiner** rowr 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2305 Edmondson Avenue **Baltimore Funeral** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 69 Months Hours Director 242-56-943 1 X M 2 F 0 Country) Yrs Usual Residence of Decedent 10a, State 10d. Inside City Limits 10b. County 10c. City, Town or Location Baltimore MDYes 2 No must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21223 Edmon Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, or items Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc Never Married 2 Married Yes Yes 2 No specify: 3 Widowed If Yes, Give Year 4 Divorced the Medical Examiner ≥ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) timore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medica 12th toreman er's Name (First, Middle Father's Name (First_Middle, Last) Be prown or Rural Route Number 80 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Burial 2 Cremation 3 Baltimore, Donation 5 Other Specify: nature of Furgeral Service Licensee 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva Physician failure. List only one cause on each line Between Onset and 'Medical Death a Cirrhosis of liver Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical X UNPENDED signed by the attending physician be detached for use as the burial #251,27,perME,g879 5/14/08 TI The law requires that the death certificate be Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown g Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 Unknown Completed ficate has been si 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? certificate ✓ Yes 2 2 No 1 🗸 the Hospital or Attending Physician: Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one Be examiner? Hospital: 1 Other₄ Nursing Home 5 Inpatient 2 ER/Outpatient 3 DOA Residence 6 🗸 Other: Scene this ို 1 Yes After 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural hours after death.

nucral Director:

ly filled in by the fi Yes 2 Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be within 24 hours af To the Funeral D determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 29, 2008 Myrie 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Margarita Korell MD. Assistant Medical Examiner 22. Registrar's Signature State Registra

		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene											
		For State Registrar		/iaryland	•			Death	R	eg. No.	008	10344	
Physicia		1. Decedent's Name (First, Middle, Las Leon P. Bon	,	•					2. Date of Deat Month March	์ 18	200 ^{ear}	3. Time of Death 5:53а м	
/Medic Examin		4a. Facility Name (If not institution, give	e street and numbe				Town, or	Location of Deat			ounty of Death	ore	
Funeral Director		Social Security Number 6. S		Age (In yrs. la 82	ast birthday) Yrs.	If Under	1 Year Days	If Under 24 Hrs Hours Min.		0 , 1 9	9. Birthp Cour	olace (State or Foreign WVA	
Maryland f show	ō	Usual Residence of Decedent 10a. State 10b. County MD			Town or Local						10d. Inside Ci 1X∐Yes		
th with the I 23a or 28a- ist be notifi	al Direc	10e. Street and Number 1052 Lerew Way		<u> </u>		10f. Zip	Code 212	205	1	-	en of What Coun	itry?	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, I'm Medical Evan has must be nuffiled at once.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceder Armed Forces 1 Yes 2 If Yes, Give Year or Dates	s?] No	lf'	/as Dece Yes, spe □Yes	cify Cuba	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		1. Race - Americ Black, White, of Specify: W		
within 72 ho jiene. r than "natur ir e Medical I	To Be Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 10th	lucation de completed) College (1-4o	r 5+)	16a. Decede (Give ki life. Di Stee]	ind of wo	rk done c	lurina most of wo	rking		of Business/Ind th Ste	_	
uld be filed Mental Hyg Irked othe		17. Father's Name (First, Middle, Last) Elmer Fay Bonnell 18. Mother's Name (First, Middle, Maiden Sur M.Flo Davis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or To									urname)		
and 2 shoter and 2 states and 1		19a. Informant's Name/Relationship (** Brian Bonnell		on	1				ural Route Number		-	,	
Pages 1 ament of He ant: If item ury or oth		20a. Method of Disposition 1 Disposition 1 Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Other (Specify) 21. Signeture of Fuderal Service Licensee 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Other (Specify) 22b. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Other (Specify) 22c. Location - City or Town, State 22d. Baltimore MD 22d. Name and Address of Facility 300 Mace Ave. Balto. MD											
permit. Depart Import any Inj		21. Signeture of Funeral Service Licen	See	ls h	22.			•	300 Mac ral Hom				
Physician /Medical		23a. Part 1. Enter the disease, condications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List ont one cause on each list. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):										Approximate Interval Between Onset and Death	
Examiner	er	Sequentially list conditions by Dincy to fenial										months	
e executed an and rial-transit	Examiner	cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):										Jean	
rificate be e ng physician as the buria	fedical		, d							1			
To the Hospital or Attending Physician: The law requires that the death certificate be within 2 drouts after death certificate has been signed by the attending physicia To the Funcaral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the bur	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □Unknown	23c. If yes, outcon 1 □ Live birth 4 □ Pregnan 9 □ Unknowr	2 ☐ Fetal tat time of de	death 3 🗌	Ectopic p Other (s	oregnancy oecify)			23	Bd. Date of delive Month	ery Day Year	
w requires that been signed b should be deta	δ	Part II. Other significant conditions of	contributing to death	es fin	lting in the und	derlying	ause give	en in Part I.				ne cause of death?	
sician: The law re certificate has be irector, page 2 sho	Completed		<i>()</i>						24a. Was a autops perforr 1 □ Yes	sv I	24b. Were auto prior to co death? 1 □ Yes	psy findings available mpletion of cause of 2 No	
Physiclan: this certific	Be	25. Was case referred to medical examiner?	Hospital:				Othe		ath (Check only on			1/	
nding Phys th, : After this e funeral dii	Certification: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of h	njury	ER/Outpatient 28b. Time of Injury		28c. Injury Work	4 <u>□ Nursing r</u> / at	Home 5 ☐ Reside 28d. Describe ho			nttospice	
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fun	Certific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of I	njury - At hor etc. <i>(Specify</i>	me, farm, stree	et, factor	, office		28f. Location (St City or Town		Number or Rura	al Route Number,	
Hospit 24 hour Funera etely fills	Medical (29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam		of examinat					e, and due to the curred at the time, d				
To the within To the compl	Me	29b. Signature and title of certifier	1 2			29	c. License	e number	2	9d. Date	signed (Month,	Day, Year)	

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (tras a consequence of): c. Mye to dys phastic syndron Due to (or as a consequence of):	ne years
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome of pregnancy 1	23d. Date of delivery Month Day Year

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) MArch 31, 2008

md 2120 x

30. Name and address of person who completed dause of death (Item 23a) (Type, Print)

W. A. R. Ley & MC 6701 N. W. A. R.L 31. Date filed (Month, Day,

State Registrar

32. Registrar's Signature Year



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Mary		artment rtificate				giene Nog. No. 2	800	10345
ì	Physici /Medio Examir	al	Decedent's Name (First, Middle, La: Second 4a. Facility Name (If not institution, give	· Pal	emar		Town, or Loc	cation of De	2. Date of Dea Month March	Bayit	Year 2008 ty of Death	3. Time of Death 8-15A M
_	Funeral Director		220-03-0713		g Cente yrs. last birthday 87 Yrs.	If Under 1	Year If	Under 24 H Hours M	rs. 8. Date of Birth	2 , 1921	9. Birthr	olace (State or Foreign ntry) MD
	e Maryland	ctor	Usual Residence of Decedent 10a. State 10b. County MD Baltime		c. City, Town or L	ocation ddle 1	River	r			1	1 ☐ Yes 2 ☐No
	h with th	ai Dire	10e. Street and Number 2131 Firethor:	n Road		10f. Zip (Code 1220			10g. Citizen o	What Cour	ntry?
9036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Introprent: If Item 27 is marked other then "natural", or Iteme 23s or 28s-f show mithoriant: If Item 27 is marked other then "natural", or Iteme 23s or 28s-f show ery fajury or other traumatic event, the Modical Esantical metal be notified at once.	d by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates:	in U.S. 13.	Was Decede If Yes, specific	_	anic Origin? Mexican, Pu Specify:	(Specify Yes or No- erto Rican, etc.)		ace - Americ ack, White, ify: Whi	etc.
Maryland 21215-0036	filed within 72 h Hygiene. other then "natuent, the Modern	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 8th	College (1-4or 5+)	16a. Dece (Give life. Pair	edent's Usual e kind of work DO NOT use nter	done durin e retired)	ng most of v		Auto)	dustry
/land	uld be fil Mental H Irked oth	To Be	17. Father's Name (First, Middle, Last) James Batemai				18.		lame (First, Middle, olla Hou		ime)	
	end 2 should saith and Mer n 27 is marke ier traumatic		19a. Informant's Name/Relationship (19a George Batema)	•					Rural Route Numbe			Code)
Baltimore,	Pages 1 e ment of Hes lant: If Item jury or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	Ob. Place of Disposition of Disposit	matory or oth	cemet	1	4/2/08	20c. Location Balti	more	MD
Ball	Departition Depart		21. Signature of Purperal Service Licent	Carrell	2	2. Name and	Address of	^{f Facility} 3 Fune	00 Mace	Ave.	Balt Essex	o. MD 21221
)	Physician /Medical		23a. Part f. Enter the disease On common shock, or heart failure. List brity immediate Cause (Final disease or condition resulting in death)	a. Bible	Mydear	dial	of dying, si	face	iac or respiratory arr	rest,		Approximate Interval Between Onset and Death
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Alual Due to (or as a cor	nsequence of):	ltim	ias	,				
8760,	icate be executed physicien end the burial-transit	cal	Costing in Goath, East	d. Reveal	nsequence of):	ure				-		
P.O. Box 6	Physician: The law requires thet the death certificate be executed this certificate has been signed by the ettending physicien end that director, pege 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \[Yes 2 \] No 9 \[Unknown \]	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3[⊒Ectopic pre ⊒ Other (spe					ate of deliver	ery Day Year
rds, P	w requires thet been signed b should be deta	by	Part II. Other significant conditions c	ontributing to death but no	t resulting in the u	underlying car	use given in	n Part I.		bacco use co es 2 □ No	ntribute to t	he cause of death?
Division of Vital Records,	n: The law re icete has be r, pege 2 sho	Completed							24a. Was a autop: perfor 1 Yes	sy	Were auto prior to co death? 1 \(\subseteq \text{Yes}	posy findings available impletion of cause of 2 No
f Vit	iysiclar is certif directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	2 ER/Outpatie	nt 3 DOA	1		eath (Check only or Home 5 Resid		ther (Specif	(v)
sion o	To the Hospital or Attending Physician: The inwiting 24 hours effer death. To the Funeral Director: Affer this certificate he completely filled in by the funeral director, page	Certification:	27. Manner of Ceath 1 Natural 5 Pending investigation		28b. Time o Injury	of 28	c. Injury at Work?		28d. Describe h			·
DÍ <u>V</u> i	tal or Att is efter de at Direct ed in by t	Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (Sp	At home, farm, st pecify)	reet, factory,	office		28f. Location (S City or Town		nber or Rura	al Route Number,
	To the Mospital or within 24 hours efter To the Funeral Dir completely filled in	edicai	29a. Certifier (Check only one) Certifying Ph	ysician: To the best of my niner: On the basis of exa- and manner stated.	/ knowledge, deal mination and/or in	th occurred a nvestigation, i	t the time, o	date and pla on, death oc	ce, and due to the c curred at the time, d	ause(s) and n late and place	nanner as s	tated. o the cause(s)
		Σ	29b. Signature and title of certifier	(.Trupe	eralin	· +	License nu	111		29d. Date sign	ed (Month,	Day, Year) 2008
	3		30. Name and address of person who of the control o	completed cause of death	(Item 23a) (Type	Print) Lallie	nole	2 - 9	d-2	123	9.	
	Sta Registr	re	31. Date filed (Month, Day, Year)	32. Registrar's S	Signature	E						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		,	ertificate of		nd Mental Hy	Reg. No.	08 10346
	Physici	ań	Decedent's Name (First, Middle, La.					2. Date of De Month	Day	3. Time of Death
	/Medic	cal	Timothy Joseph 4a. Facility Name (If not institution, give			4b. City, Town, o	as Location of	March	28, 2008 4c. County	
	Examir	ier	1914 Bennett Ro	·		Aberde		Doan	Harfo	
	Funeral		5. Social Security Number 6. S		(In yrs. last birthda)) If Under 1 Year	If Under 2			Birthplace (State or Foreign Country)
	Director		220-74-0472	© M 2□F	17 Yrs.	Months Days	Hours	June 3	0, 1960	Maryland
	pu ,		Usual Residence of Decedent		10- Cit. T					10d. Inside City Limits
	aryla shov	5	10a. State 10b. County		10c. City, Town or I					1 Yes 2 No
	28a-f	Director	Maryland Harford 10e. Street and Number		Aberdeer	1 10f. Zip Code			10g. Citizen of	What Country?
	with	급	1914 Bennett Roa	a a		21001			USA	Trial County.
	72 hours after death with the Maryland natural', or Items 23s or 28s-f show distal Examinat must be notitled at	Completed by Funeral	1914 Definect Road	12. Was Decedent E	ver in U.S. 13		Hispanic Origi	in? (Specify Yes or No Puerto Rican, etc.)		ce - American Indian,
9	after of the second	교	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 25 No				Puerto Rican, etc.)		ck, White, etc.
21215-0036	ral', c	d by	3√ Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀No	Specify:		Specil	White
5-0	72 h "natu	etec	15. Decedent's Ed (Specify only highest gra	fucation de completed)	16a. Dec (Giv	edent's Usual Occup e kind of work done DO NOT use retire	oation during most	of working	16b. Kind of 8	Business/Industry
121	within ene. than *	E E	Elementary/Secondary (0-12)	College (1-4or 5+	•)		(a)		Trangr	ortation
	Hyg ther nt.		12 17. Father's Name (First, Middle, Last)		Drive	#L	18. Mother	's Name (First, Middle		
an	id be ental ked o	To Be	Earl Seymore Bos	lev			Hilda	Lorraine	Egbert	
Maryland	s 1 and 2 should be t Health and Mental is tem 27 is marked o other treumatic eve	-	19a. Informant's Name/Relationship (-	19b. Mai	ling Address (Street	and Number	or Rural Route Numb	er, City or Town	, State, Zip Code)
	5 4 5 5 E		Hilda Bosley / M	other	1914	1 Bennett	Rd., 2	Aberdeen,	MD 21001	1
Ore	ges 1 au t of Hea if Item or othe		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐	Removal from State		position (Name of ematory or other pla		Date		- City or Town, State
Ĕ	Pag ment ant: I		4 Donation 5 Other (Specif		Dulaney	Valley M	em. 4	-2 - 08	Timoni	um, Maryland
Baltimore,	permit. Pages. Depertment of H Important: If Ite any Injury or of once.		21. Signature of Funeral Service Licer	ian Roum	t			l Home, P. Road, Abi		MD 21009
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or comshock, or hear failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a Due to (or as a C.	consequence of):		A	mardiac or respiratory a	arrest,	Approximate Interval Between Onset and Death I MM K
.O. Box 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	y			ate of delivery onth Day Year
Records, P.	uires that signed by Id be deta	þ	Part II. Other significant conditions of	01	t not resulting in the	underlying cause gr	ven in Part I.		tobacco use con	ntribute to the cause of death?
COL	w requir s been si should	lete	Hyperten	sion				24a. Wa		Were autopsy findings available
al Re	The lay	Completed						auto peri 1 🗆 Yes	ormed? 2 No	prior to completion of cause of death? 1 Yes 2 No
Vital	sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		Ott	her	of Death (Check only	/	
of	Phys rthis ral dii	To	1 Yes 2 W6	1 🗆 Inpatier		ent 3 DOA	4 Nui:	sing Home 5 Tes	how injury occu	her (Specify)
o	ding F h. After funer	tlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year) Injury	Wo	nk?]Yes 2 □ N			
Division	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not b		ry - At home, farm, s (Specify)	street, factory, office			(Street and Num own, State)	iber or Rural Route Number,
	ne Hospital or 24 hours afte ne Funeral Direction bietely filled in b	Medical (nysician: To the best on the basis of and manner state.	examination and/or					nanner as stated. , and due to the cause(s)
	within 7 to the comple	M	29b. Signature and the of certifier	Attend	ding		se number	144	29d. Date sign	ed (Month, Day, Year) w 29th 2008
	6		30. Name and address of person who	VAIRM	D. 60	9, Print) 25.	ATWE	DOD Rd	Polai	ch 29th 2008
	Sta Regist		31. Date filed (Month, Day, Year) APR 0 1	2008 32. Projestra	r's Signature	Societ !				

Bosley, Timothy

State Registrar

31. Date filed (Month, Day, Year)

APR 0 1 2008

DAVID O. NYANTOM MD. 10724 LITTLE PATURENT PARKENTY . Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Joseph

GRUMIA MO 21544

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Amend item 19a	State of Ma per FH g878 4/	ryland/De 1/08 amh C	partment of F e <i>rtificate of</i>	lealth and <i>Death</i>	Mental Hygie	ne No. 2008	10348
	Physici	an	Decedent's Name (First, Middle, L	.ast)	-			2. Date of Death Month	Day Year_	3. Time of Death
	/Medi	cal	ALBERTHA 4a. Facility Name (If not institution, g	ive street and number)	BK	OOKS	or Location of Dea	11	200 2008 4c. County of Deat	1800 M
1	Examir	ier	GOOD SAMARITAN		ENTER	BALTI		ITY	4c. County of Deal	
	Funeral Director		5. Social Security Number 6. 230–22–8058	7 4 9 11 4	(In yrs. last birthda 88 Yrs.		If Under 24 Hr Hours Mir		ear) Co	nplace (State or Foreign untry) MD
	land W		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Mary a-f ah	tor	MD			Baltimore	:			1 ☑ Yes 2 ☐ No
	th with the 23a or 28	Funeral Director	10e. Street and Number 5512 Tramore Road			10f. Zip Code 212	14	10g.	. Citizen of What Co USA	untry?
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28s-f show or other traumatic event, the Medical Examinar must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2XXNo	dispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No- into Rican, etc.)	14. Race - Ame Black, White Specify: B]	
50	72 ho	eted	15. Decedent's (Specify only highest of	Education trade completed)	16a. De	cedent's Usual Occup ve kind of work done b. DO NOT use retired	pation during most of w	orking 16i	b. Kind of Business/	ndustry
12	within ane. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+) life	nurse aid	d)		health car	re
<u>q</u>	illed Hygir other	Be Co	17. Father's Name (First, Middle, Las	st)			18. Mother's Na	ame (First, Middle, Mai		
ylar	should be ind Mental marked c	ToB	Willie Thor	nas				Annie Thomas		
, Maryland 21215-0036	and 2 sho ealth and n 27 is m		19a Informant's Name/Relationship Catherine Robinson Cathern M.	(Type, Print) Granddaughte:				Rural Route Number, C Con, Virginia		(ip Code)
Baltimore,	E Page		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Special Control of the Control	cify)			03/3	31/2008 Bal	Location - City or Limore, Mar	
Ball	permit. Depertr Importa eny Inju		21. Signature of Funeral Service Lic	ensee				Wylie Funeral		
			23a. Part1. Enter the disease, or co	mplications that caused	the death. Do not			Baltimore, M		Approximate
\$	Physician /Medical Examiner		shopk orheart failure. List onlined face Cause (Final disease or condition resulting in death)	Stro	consequence of):					Interval Between Onset and Death
	pe sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequence of):					
ر 0	icate be executed physicien and s the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):					
68760,	physics the p	dical		d						
.O. Box (The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknowh	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at the 9 ☐ Unknown	Fetal death	3□Ectopic pregnancy 5□ Other (specify) _	/		23d. Date of deli Month	very Day Year
ds, P	w requires thet s been signed by should be deta	d by Ph	Part II. Other significant conditions Demontia . Hvo		t not resulting in the		ren in Part I.	23e. Did tobac		the cause of death?
Division of Vital Records,	The law req	Completed by			J	y		24a. Was an autopsy performer	d? prior to death?	topsy findings available completion of cause of
ţ		Be C	25. Was case referred to medical examiner?				26. Place of De	1 ☐ Yes 2.X eath (Check only one)	INO TO THE	2 No
<u>></u>	Attending Physician: It death. ector: After this certifict by the funeral director.	ဥ	1 ☐ Yes 2 No		t 2 ER/Outpat		4 Nursing	Home 5 ☐ Residence		cify)
00	ding f h. After funer	tlon	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigati	28a. Date of Injury (Month, Day	Year) 28b. Time Injur	/ Wor	yat k? Yes 2.∐No	28d. Describe how	injury occurred	
Divisi	o # in ⊆	Certification;	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	he	ry - At home, farm, (Specify)	street, factory, office		28f. Location (Stree City or Town, S	at and Number or Ru State)	ral Route Number,
	To the Hospitel or A within 24 hours after of the Funeral Directompletely filled in by	edical C	29a. Certifier (Check only one) 1 Certifying F	Physician: To the best of aminer: On the basis of aminer state	examination and/or	ath occurred at the tir investigation, in my o	me, date and place pinion, death occ	ce, and due to the caus curred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the Ho within 24 I To the Fu completely	Me	29b. Signature and title of certifier	6		29c. Licens		1	Date signed (Monti	•
			Jame (riatric Physic	cian I	46439	18 1 Ne, MP 21	MARCH 20	6,200 8
	2		30. Name and address of person with	completed cause of de	ath (Item 23a) (Typen DI.	e, Print)	Pa Odin	no 115 2	1739	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	sur I	welling.	100, MIX 21	21	
	Registr	ar	ADD A 1	2008	K	books				
DH	MH 17 Rev 1/2	001	MINU	LOUD JOUR						

ORIGINAL

State

OCME

30. Name and address of person

31. Date filed (Month, Day, Year)

Melissa Brassell, MD

ORIGINAL

111 Penn Street, Baltimore, MD 21201

who completed cause of death (Item 23a)

Assistant Medical Examiner

Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Harry Cottrill Jr. 29, 2008 21:13 March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Upper Chesapeake Hospital Belair If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 65 Yrs. 217-38-1467 September 4,1942 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10b. County ms 23a or 28a-f short must be notified at 1 ☐ Yes 2X No Director Maryland Harford Darlington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21034 USA 4827 Conowingo Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. "natural", or iten 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ZNo Specify: Specify: White 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Transportation 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry N. Cottrill Sr. Blanche Louise Wilhelm 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 is r 4827 Conowingo Road, Darlington, Maryland 21034 Edith Cottrill wife ltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition April 4 1 Burial 2 □ Cremation 3 □ Removal from State Cardens Of Faith Cemetery Rosedale, Maryland 2008 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature Juneral Service License 22. Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 ra 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sh. ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm di . Cause (Final disea e or condition resulting in death) Probable ventrialar **Physician** arrhythmia /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): hear Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician and the burial-transit law requires that the death certificate be executed Due to (dr as a consequence of): Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4☐Pregnant at time of death 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Fobably 4 Unknown Completed fibrillation. atria 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Chronic 24a. Was an certificate aortic aneury lospital or Attending Physician; hours after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 24 hours after death e Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Lecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated.

0168410 Box 68760 Ö Records, Division or Vital within 2

29

Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500

32. Registrar's Signa

DHMH 17 Rev 1/2001

Upper Chesapeake

29c. License number

D40365

29d. Date signed (Month, Day, Year)

Med Center Bel Air, mp 2/014

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 28°, 2008 March 1:15 A M Florence V. Codd /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 47 Boone Trail Severna Park Anne Arundel 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Days 1 □ M 2 X F 88 220-12-8716 Director Oct 12, 1919 Usual Residence of Decedent is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 47 Boone Trail 21146 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏖 No Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sophia Cheelsman George Weaver 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health a Important; if Item 27 is any Injury or other trauonce. Francis I. Codd, Husband 47 Boone Trail Severna Park, Maryland 21146 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 03/28/08 Baltimore, Maryland ²², Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 21. Signature of Funeral Service Licensee Thomas Gregor 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final literios claratic Physician baus disease or condition resulting in death) /Medical Due to (or aş a consequence of): Examiner Des if any, leading to immediate cause. Enter Underlying Cause (Disease or injury certificate be executed burial-transi and resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical the attending | for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) P.0. the detached 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 | Yes 2 | No 3 | Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Jas autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner?
1 ✓ Yes 2 ☐ No funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 \sum Nursing Home 1 🔲 Inpatient 2 ER/Outpatient 3 DOA ၉ 5 Residence 6 □Other (Specify) After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide foretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29b. Signature

Registrar

State

1600 Cram Holiway

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1.0

DOH,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Edward Conway 2008 larc /Medical City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number Examiner Baltimore, Naryland Jano 8. Date of Birth (Month, Day, Year) March 11,1928 5. Social Security Number f Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Hours 1 XM 2 ☐ F 80 Louisiana Director 214-22-2227 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10h. County 10c. City, Town or Location 10d. Inside City Limits 10a State "natural", or items 23a or 28a-f show edical Exa⊡lner must be notified at 1 Yes 2 □ No Director N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2129 Callow Avenue 21217 **USA** Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Specify: Black 21215-0036 1 ☐ Yes 2 🕅 No Specify. 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Construction i. Pages 1 and 2 should be filed witnert of Health and Mental Hygier tant: If item 27 is marked other the jury or other traumatic event, the and 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leonard Day Unk. Day 2 Itimore, Mary 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Conway, Wife 2129 Callow Avenue Baltimore, Maryland 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any Injury or 03/30/08 Baltimore, Maryland Metro Crematory Inc. 21. Signature of Funeral Service Licensee Thomas Gregor ²² Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Bal 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Umon sequentially flet our citics of any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE for use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown 9 Unknown as been signed 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Winknown Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed page certificate 1∐ Yes 2 No Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2[1/No Medical Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

within 24 hours after death.

To the Funeral Director: /
completely filled in by the f Hospital

State

(Check only

29b. Signature and title of certifier

APR O

Registrar

DHMH 17 Rev 1/2001

Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month. Dav.

32. Registrar's Signature

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month. Dav. Year)

Division or Vital Records, P.O. Box 68760,

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed sician and burial-trans Physician: or Attending after death Director: filled in by To the Hospital c within 24 hours af To the Funeral D completely filled i

Medical State

31. Date filed (Month, Day, Year) 2008 APR U 1 Registrar

29b. Signature and title of certifier

29a. Certifier (Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rakesh Arora 14300 Gallant Fox Lane #222 Bowie, MD 20715 32. Registrar's Signature

and manner stated.

🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

m

Registrar
DHMH 17 Rev 1/2001

State

RIDGE

COLUMBIA

21044

MA

Hickeny

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10802

32. Registrar's Signature

MATEEN AWAN

1ª 2008

31. Date filed (Manth Day.

DHMH 17 Rev 1/2001

Registrar

30

4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month CRAWFORD Day Year **Physician** u c r2008 March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner andallstown 1405P1 721 Baltimore 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthdav) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M **%**□F Months Days Hours Director 213-20-3102 30 09 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1√Yes 2□No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a or 5309 Wesley Ave Funeral 21207 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X 1 Never Married 2 Married 1 ☐ Yes 2√2 No Specify: Completed by Specify: 3 Widowed 4 □ Divorced Black Year or Dates "natural" 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home 2yrs 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental F Be William Richardson Francis Curtis ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any injury or other trau once. 5309 Wesley Ave, Baltimore, Md William Crawford-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 4/2/08 Owings Mills, 21. Signatur 22. Name and Address of Facility March F/H West of Funeral Service Licens 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician PSUS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Liseas of injury that initiated events resulting in death) Last Due to (or as a consequence of): Exam burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No page 2 autopsy performed? 2 1No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Avatural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, attending physician for use as the buria ed by the a signed to certificate After this after death filled in by . 24 hours a e Funeral I completely To the the

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

within:

State Registrar

Medical

31. Date filed (Month

Deen

29a. Certifier

(Check only one)

29b. Signature and title of certifier

29c. License number 65843 29d. Date signed (Month, Day, Year)

March, 25, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32 Registrar's Signatur Road, Randallstown, 17D 21133 Karrouni

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

odney Darrin C		State of Maryland / Department of Health and N 1- For State Certificate of Death	Mental Hygie		200	9 1035
Dhysicia	_	Registrar 1. Decedent's Name (First, Middle,Last)	2 Dat	Reg. I te of Death	No. 6. 0	3. Time of Death
Physicia edical Examin	11/4	Rodney D. Cox	l Mo		y Year	1615 hrs
oulou. Exami		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Loc		101 22, 20	4c. County of Dea	1
		Johns Hopkins Hospital Baltimore				
Funeral			If Under 24Hrs. 8. D	ate of Birth(MM/DD/YYYY) 9. B	irthplace (State or
Director		Months Days	Hours Min.	1-12	Fore	ign ountry) M7
	9	Usual Residence of Decedent		1-12-	1966	·····, / 1/)
ģ	ŀ	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
d d		MA Do Ition and				1 Yes 2 No
rylan ia-fs	용	10e. Street and Number 10f. Zip Code		10g.	Citizen of What Co	untry?
or 28	Director	3400 E. Fool and Short 12121	72		1100	ŕ
ith th	<u>=</u>	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispar	inic Origin? (Specify)	Yes or No-	14 Race - Ame	erican Indian, Black,
-death with the Maryland or items 23a or 28a-f show any must be nedified at once	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, M			White, etc.	, and the second
·		3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No s	specify:		Specify:	31adC
72 hours after u "natural", c	à	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation		one 16	6b. Kind of Busines	s/industry
2 p	Completed	Elementacy/Secondary (0-12) College (1-4 or 5+) during most of working life. DO	O NOT use retired)		1 1	., ,
036 Thin That	린	194h Janitoria	/		1-10SA	ortal
21215-0036 Id be filed within 72 hours after Aental Hygiene. narked other than "natural" event, the Medical Examines	ड		.Mother's Name (First	, Middle, Mai	den Surname)	
2121; ould be fill Mental I. marked c event, 1	Be	Llames E. Cox	Amelia	LA	·Wind	70
	ျ	19a. Informant's Name/Relationship (Type, Print)	and Number or Rural F	Route Numbe	r, City or Tow	te, Zip Code)
e, MD I and 2 shu Health and item 27 is	1	Bertha M. (angley (Grandrether) 3042 E.	redera	<u> 15+.</u>	Ba110.	MD2/2/3
nore, MD 2 ages I and 2 shou nt of Health and It: If item 27 is n other traumatic		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State crematory or other place)	· .		0c. Location - City	·
altimore, rmit. Pages I a spartment of He iportant: If its		4 Donation 5 Other Specify: King Menorial An	RK 3/29	108 .	Balto.	MD
Balti permit. Departm Imports injury c	- 1	21. Symature of Funeral Service Licensee 22. As me and Andress of	Fracility	0. 77	100015	roices
ದ ಷನ≛≣	_ 11	Un U. Son yansil	SAICICE.	Rall	MD	21212
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying surfailure. List only one cause on each line.	uch as cardiac or resp	iratory arrest	, shock, or heart	Approximate Interval Between Onset and
'Medical xaminer		Immediate Cause (Final disease a. Cardi megaly				Death
Adminion		or condition resulting in death) Due to (or as a consequence of):				
	<u>.</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	Examiner	cause. Enter Underlying Cause				
" ; Z"	xan	(Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		-		
and and transit		d				
be experient	edical	AMENDED23a,Pt.II,27 per ME g878 5/1/09	18 amh			
cox 6876C eath certificate attending phys		IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the	7		23d. Date of deliv	
68 certif	ä	past 12 months? 2 Petal death 2	Ectopic pregnancy		Month	Day Year
Box 6876: death certificate the attending phy	Physician/M	1 Yes 2 No 9 Unknown 9 Unknown				
that the de detached f		Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	en in Part I.	23e. Did toba	acco use contribute	to the cause of death?
ires that the signed by	b	Cocaine Use	- 1	1 Yes	2 No 3 P	robably 4 🗸 Unknown
Division of Vital Records, lal or Attending Physician: The law requir rs after death. al Director: After this certificate has been sted in by the funeral director, page 2 should to	Completed			24a. Was an		autopsy findings available
cords law requi has been	힅			autopsy perform	ed? death	
tal Reciant The I	흥		1	Yes 2	No 1 🗸	Yes 2 No
ital ician: s certif	8	examiner?	ther Nursing Hor			
f Vit	욘	1 Ves 2 No Pospital: 1 Inpatient 2 V ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury 2			esidence 6 Ot w injury occurred	her:
n of ding Ph	Certification:	(Month, Day, Year)	es 2 No	Describe no	w injury occurred	
ivisior or Attend after death Director:	g	2 Accident Investigation		Location (Str	and Number or	Rural Route Number, City
Divis pital or At ours after d eral Direc	Ħ	3 Suicide 6 Could not be determined (Specify)		or Town, Sta		Rural Route Number, Oity
E 8 E E		14 Homicide	a and also a single	la the '	a) and man ====	totod
To the Hos within 24 h To the Fur completely	ica	23a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date (Check only one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, d	e and place, and due t death occurred at the	to the cause(time, date an	s) and manner as s nd place, and due to	tated. the cause(s)
To t To t	Medical	and manner stated. 29b. Signature and title of certifier 29c. License r			29d. Date signed (i	
		250. Digitation and the of continuous			March 23, 200	
		Dance to Otto				
d		30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, E	Baltimore, MD 21	1201		
4	ate					
Regist	trar					

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-02440 State of Maryland / Department of Health and Mental Hygiene Nannie R. Chambers 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ March 28, 2008 0637 hrs Medical Examiner NANNIE **CHAMBERS** 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number Baltimore Good Samaritan Hospital If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number **Funeral** Foreian Min. Days Months Hours Director Country) 1 M 2 X F 231-38-2762 09/15/1930 Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location 'n 1 X Yes 2 No BALTIMORE TURNER STATION MD Director 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code 1 SOUTH LANE 21222 USA or items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Yes 2 X No f Yes, Give Year Yes 2 No specify: Specify: BLACK 3 X Widowed 4 Divorced the Medical Examiner ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) within 72 permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "injury or other traumatic event, the Medical. Baltimore, MD 21215-0036 2 NURSES AIDE HEALTH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) HENRY BRANDON NANNIE HAMLETT Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **EVELYN SIMS/DAUGHTER** SOUTH LANE, BALTO., MD 21222 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 04/03/08 ARBUTUS MEM. PK. BALTIMORE, MD 4 Donation 5 Other Specify: 22. Name and Address of Facility JAMES A. MORTON & SONS F.H.INC 21. Signature of Funeral Service Licenses when 1701 LAURENS ST., BALTO., MD 21217 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. /Medical Death a. Hypertensive Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Car (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit executed Physician/Medical AMENDED 23a,27 per ME g878 4/21/08 amh X UNPENDED the attending physician led for use as the burial -The law requires that the death certificate be Records, P.O. Box 68760, 23d Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Day Year 3 Ectopic pregnancy Month Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 V No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 V Unknown Completed certificate has been ector, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? Yes 2 1 🗸 Yes No 26.Place of Death (Check only one) Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Division of Vital Be DOA Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 After this 1 🗸 Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27 Manner of Death Certification: within 24 hours after users.

To the Funeral Director: A 1 X Natural 1 Yes 2 No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie March 29, 2008 O.C.M.E.

De State

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD 31. Date filed (Month, Day, Year)

2008

32 Registrar's Signature

ORIGINAL

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month March 31, 2008 12:10P M MARY ANCILLA CASTELLANO 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Maria Health Care Center Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 0ct 1, 1912 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Months Days 212-58-6741 1 □ M 2**X**C)(F 95 New Jersey Usual Residence of Decedent 10a State 10c. City. Town or Location 10b County 10d. Inside City Limits 1 ☐ Yes 🏋 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21212 6401 North Charles Street USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. Wever Married 2 Married 1 ☐ Yes XX No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Teacher Parochial School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vincenzo Castellano Anna Moles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6401 North Charles Street Baltimore, Maryland 21212 19a. Informant's Name/Relationship (Type. Print) S. Bernice Feilinger SSND 20a. Method of Disposition XX Buriat 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Villa Maria Cemetery 4/4/08 20c. Location - City or Town, State Glen Arm, Maryland 4 Donation 5 ☐ Other (Specify) nature of Funeral S 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) i day Due to (o as a consequence of) alvular He nears if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day Year 4□Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an Auxieta 1∐ Yes 25. Was case referred to inedica examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 X No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation

Examiner siclan and Surial-transit or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, the attending p for use as 1 ed by the a has certificate hai this After 1 death. after death in by within 24 hours af

To the Funeral D

completely filled i

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

o e

"natural", or items ?

ed other than "natu

27 is marked c

permit. Pages 1 and 2 a Department of Health at Important: If Item 27 is any Injury or other trau once.

Physician

/Medical

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Director

by Funeral

Completed

Examine Physician/Medical Be Completed by Medical Certification: To 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie,

State Registrar

111 31. Date filed (Month, Day, Year)

APR 0 1 2008

30. Name and address

32 Registrar's Signature

eo cau e of death (Item 23a) (Type, Print)

#312, Towson, MD 21204

			1 - For State Registrar		Cei	rtificate of	Death	F	Reg. No.	0360
	Physici		1. Decedent's Name (First, Middle, La	Christian				2. Date of Dea Month March	ath Day Year Z8 Z008	3. Time of Death 5:07 PM
	/Medic Examin		4a. Facility Name (If not institution, give	ve street and number)	enter	4b. City, Town, o	or Location of Death		4c. County of Dea	
	Funeral	14 ·	Johns Hopkins Bay 5. Social Security Number 6.5	Sex 7. Age (In yrs.		If Under 1 Year	If I Index 24 Hrs	8. Date of Birt	b 0.0%	rthplace (State or Foreign
	Director		340-22-4876 Usual Residence of Decedent	% M 2□F 75	Yrs.	Months Days	Hours Min.	June 21	, 1932 Mar	'y land
	iryland thow	_	10a. State 10b. County		, Town or Lo					10d. Inside City Limits
	the Ma 28a-f s notifiled	Director	MD Baltim 10e. Street and Number	ore	Baltim	10f. Zip Code			10g. Citizen of What C	1 □ Yes 2 💢 No
	ath with 23a or ust be	ral Di	3522 Louth Road			2122	2		U.S.A	
36	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U. A/med Forces? 1/1 Yes 2 No If Yes, Give Year or Dates: Korea	l l	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2X No	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify:	
215-0036	72 hou natura lical E		15. Decedent's E (Specify only highest gr	ducation	16a. Dece	dent's Usual Occu	pation during most of wor	kina ı	16b. Kind of Business	
	within lene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	l .		during most of word d) force	9	Military	
ממ	al Hyg	Be C	17. Father's Name (First, Middle, Last	*	7		18. Mother's Nam		Maiden Surname)	
Maryland 21	2 should be and Mental is marked o aumatic eve	은	Arthur F. Christ		10b Mailir	na Address (Street	Viola	Stiles	er, City or Town, State,	Zin Codo)
	마 는 다. 후		Sandra M. Christi			-			aryland 212	. ,
Baltimore,	permit. Pages 1 and Department of Healt Important: If Item 2 any Injury or other once,		20a. Method of Disposition 1 Burial 2 Cremation 3	Intellioval Ilolli State	lace of Disponentery, crea	osition (Name of matory or other pla	orp. 3/31	Date / O Q	20c. Location - City of Towson, Mar	_ `
atin	mit. Papartme portant y Injury		4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice	·	22	2. Name and Addre	ess of Facility DU	ida-Ruck	F.H. of Du	undalk, Inc.
n	o E u		Henen	(an)					Maryland 2	
	Physician		23a. Part1. Enter the disease, or con shock, or heart failure. List only immediate Cause (Final		-	ter the mode of dyl	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Respirator		we				Z weeks
	Evaminer			Due to (or as a consequence)	uence of):					- /
	Examiner	er	Sequentially list conditions, if any, leading to immediate	b. Sepsis Due to (or as a consequ	uence of):	11				2 weeks
	2	kaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Unidentifing Cause (Disease or injury that initiated events resulting in death) Last	b. Sepsis Due to for as a consequence. Metastation	uence of):	amous (Concer	To Facility day on		Z weeks Months
/60,	2	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Liner Uniterining Cause (Disease or injury that initiated events resulting in death) Last	b. Sepsis Due to (or as a consequ	uence of):	oamous (Coucer			
x 68/60,	tificate be executed g physician and as the burial-transit	ledical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Sepsis Due to (or as a consequence) C. Due to (or as a consequence) Due to (or as a consequence)	uence of):	oanous (Concer			
C. Box	tificate be executed g physician and as the burial-transit	ledical	resulting in death) Last	b. Sepsis Due to for as a consequence. Metastation	uence of): uence of): uence of): ancy I death 3	De noous (23d. Date of de Month	Months
P.O. Box	tificate be executed g physician and as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions	b. Sepsis Due to (or as a consequence) C. Due to (or as a consequence) Constitution of the consequence) Constitution of the consequence of the conse	uence of): uence of): uence of): ancy I death 3E eath 5E	⊒Ectopic pregnanc ∃ Other (specify) _	:y		Month obacco use contribute	Mont's elivery Day Year to the cause of death?
P.O. Box	requires that the death certificate be executed to require signed by the attending physician and should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	b. Sepsis Due to (or as a consequence) C. Due to (or as a consequence) Constitution of the consequence) Constitution of the consequence of the conse	uence of): uence of): uence of): ancy I death 3E eath 5E	⊒Ectopic pregnanc ∃ Other (specify) _	:y	12	Month obacco use contribute Yes 2 No 3 F	Months elivery Day Year to the cause of death? Probably 4 Unknown
Records, P.O. Box	requires that the death certificate be executed to require signed by the attending physician and should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions	b. Sepsis Due to (or as a consequence) C. Due to (or as a consequence) Constitution of the consequence) Constitution of the consequence of the conse	uence of): uence of): uence of): ancy I death 3E eath 5E	⊒Ectopic pregnanc ∃ Other (specify) _	:y	24a. Was autor perfo	Month bacco use contribute Yes 2 No 3 F an 24b. Were a prior to death?	Day Year to the cause of death? Probably 4 Unknown autopsy findings available occupietion of cause of
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions Coronery Artery 25. Was case referred to medical examiner?	b. Sepsis Due to (or as a consequence) C. Meta static Due to (or as a consequence) d. 23c. If yes, outcome pf pregnate to the constant of dependence of d	uence of): uence of): uence of): ancy I death 3E eath 5E	□Ectopic pregnand □ Other (specify) _ Inderlying cause gi	ven in Part I. 26. Place of Dea	1 das 24a. Was autor perfo 1 Yes	Month Obacco use contribute Yes 2 No 3 F an 24b. Were a prior to death? 2 No 1 Yes	Months elivery Day Year to the cause of death? Probably 4 Unknown autopsy findings available of completion of cause of
or Vital Records, P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions Coronery Artery 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	b. Sepsis Due to for as a consequence. Meta static Due to for as a consequence. 23c. If yes, outcome pf pregna 1 Live birth 2 Feta 4 Pregnant at time of definition of the second secon	uence of): uence of): uence of): uence of): l death 3 [eath 5 [ulting in the uence of):	□Ectopic pregnand □ Other (specify) □ Inderlying cause gi	ey ven in Part I. 26. Place of Dea her: 4 □ Nursing H	24a. Was autor performent (Check only of the Check only of the Ch	Month Obacco use contribute Yes 2 No 3 F an 24b. Were a prior to death? 2 No 1 Yes	Probably 4 Unknown autopsy findings available completion of cause of
or Vital Records, P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Sepsis Due to for as a consequence. Meta static Due to for as a consequence. 23c. If yes, outcome pf pregna 1 Live birth 2 Feta 4 Pregnant at time of definition of the second of the secon	uence of): uence of): uence of): l death 3E eath 5E ulting in the u ER/Outpatier 28b. Time o	□Ectopic pregnand □ Other (specify) □ Inderlying cause given the second	ey ven in Part I. 26. Place of Dea her: 4 □ Nursing H	24a. Was autop performent of the Check only only only only only only only only	Month obacco use contribute Yes 2 No 3 F an 24b. Were a prior to death? 2 No 1 Ye one) dence 6 Other (Sp. now injury occurred	Probably 4 Unknown autopsy findings available a completion of cause of secify)
Vital Records, P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to for as a consequence. Meta static Due to for as a consequence. Due to for as a consequence. 23c. If yes, outcome pf pregnance and the pregnant at time of description of the pregnant at time of descripti	uence of): uence	□Ectopic pregnand □ Other (specify) □ Inderlying cause given the second	ven in Part I. 26. Place of Deaner: 4 \(\) Nursing H	24a. Was autop performent of the Check only only only only only only only only	Month obacco use contribute Yes 2 No 3 F an 24b. Were a prior to death? 2 No 1 Ye one) dence 6 Other (Sp. now injury occurred	Probably 4 Unknown autopsy findings available a completion of cause of secify)
or Vital Records, P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edical Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Sepsis Due to (or as a consequence) C. Meta static Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) 1 Live birth 2 Feta Pregnant at time of december of the second of the sec	uence of): uence of): uence of): uence of): uence of): uence of): uence of): Each 3E eath 5E ulting in the u ER/Outpatier 28b. Time of Injury ome, farm, str	Dother (specify) Int 3 DOA Other (specify)	ven in Part I. 26. Place of Dea her: 4 \(\text{Nursing H} \) ry at rk?] Yes 2 \(\text{No} \) ime, date and place	24a. Was autop perfor 1 Yes th (Check only of the Check on the Check on the Check on the Check of the Check on the Check on the Check of t	Month Obacco use contribute Yes 2 No 3 F an 24b. Were a prior to death? 2 No 1 Ye Other (Sp now injury occurred Cause(s) and manner a	Probably 4 Unknown autopsy findings available of completion of cause of secify) Rural Route Number, as stated.
or Vital Records, P.O. Box	requires that the death certificate be executed to require signed by the attending physician and should be detached for use as the burial-transit	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions COCOAST Arrival Due to (or as a consequence) C. Due to (or as a consequence) Due	uence of): uence	Dother (specify) _ onderlying cause given the secured at the truestigation, in my	ven in Part I. 26. Place of Dea her: 4 \(\text{Nursing H} \) irv at rx?] Yes 2 \(\text{No} \) ime, date and place opinion, death occu- se number	24a. Was autop performence of the Check only of the Check only of the Check only of the Check only of the Check only of the Check only of the Check on the Check on the Check on the Check of the Check on the Check of the Check	Month bbacco use contribute res 2 No 3 F an 24b. Were a prior to death? 2 No 1 Ye bene) dence 6 Other (Sp now injury occurred Street and Number or F vn, State) cause(s) and manner a date and place, and date 29d. Date signed (Montal Contribute)	elivery Day Year to the cause of death? Probably 4 Unknown autopsy findings available of completion of cause of is 2 No Rural Route Number, as stated. ue to the cause(s)	
or Vital Records, P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	edical Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to for as a consequence. Meta static Due to for as a consequence. Due to for as a consequence. Due to for as a consequence. Due to for as a consequence. Due to for as a consequence. Pregnant at time of description of the sequence. Disease Hospital: 1 Impatient 2 Description. 28a. Date of Injury (Month, Day Year) Disease 28a. Place of injury - At he building, etc. (Specification). Disease Disease Completed cause of death (Item).	uence of): uence of): uence of): uence of): uence of): uence of): leath 3 [eath 5 [ulting in the uence of the content	Dectopic pregnance Other (specify) Interpretation of the control o	ven in Part I. 26. Place of Dea her: 4 \(\text{Nursing H} \) irv at rx?] Yes 2 \(\text{No} \) ime, date and place opinion, death occu- se number	24a. Was autop performence of the Check only of the Check only of the Check only of the Check only of the Check only of the Check only of the Check on the Check on the Check on the Check of the Check on the Check of the Check	Month bbacco use contribute res 2 No 3 F an 24b. Were a prior to death? 2 No 1 Ye bene) dence 6 Other (Sp now injury occurred Street and Number or F vn, State) cause(s) and manner a date and place, and date 29d. Date signed (Montal Contribute)	elivery Day Year to the cause of death? Probably 4 Unknown autopsy findings available of completion of cause of is 2 No Rural Route Number, as stated. ue to the cause(s)
or Vital Records, P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Medical Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to for as a consequence. Meta static Due to for as a consequence. Due to for as a consequence. Due to for as a consequence. Due to for as a consequence. Due to for as a consequence. Pregnant at time of description of the sequence. Disease Hospital: 1 Impatient 2 Description. 28a. Date of Injury (Month, Day Year) Disease 28a. Place of injury - At he building, etc. (Specification). Disease Disease Completed cause of death (Item).	uence of): uence of): uence of): uence of): uence of): uence of): leath 3 [eath 5 [ulting in the uence of the content	Dectopic pregnance Other (specify) Interpretation of the control o	ven in Part I. 26. Place of Dea her: 4 \(\text{Nursing H} \) irv at rx?] Yes 2 \(\text{No} \) ime, date and place opinion, death occu- se number	24a. Was autop performence of the Check only of the Check only of the Check only of the Check only of the Check only of the Check only of the Check on the Check on the Check on the Check of the Check on the Check of the Check	Month bbacco use contribute res 2 No 3 F an 24b. Were a prior to death? 2 No 1 Ye bene) dence 6 Other (Sp now injury occurred Street and Number or F vn, State) cause(s) and manner a date and place, and date 29d. Date signed (Montal Contribute)	elivery Day Year to the cause of death? Probably 4 Unknown autopsy findings available of completion of cause of is 2 No Rural Route Number, as stated. ue to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 1:25 PM Civitarese March 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner St. Agne Himore N/A Year If Under 24 Hrs. 8. Date of Birth
Days Hours Min. December 10, 1917 If Under Age **9**0 9. Birthplace (State or Foreign **Funeral** 202-10-4047 Days Months 1 ☐ M 2 🗶 F Pennsylvania Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 3a or 28a-f show t be notified at 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Director Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a U.S.A. 46 Dungarrie Road 21228 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify Specify: White à 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) is marked other than College (1-4or 5+) Homemaker Own Home or and 2 should be file of Health and Mental Hyu 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vincent Yannacone Carolina Saporito ၉ Je, Mc

"ermit. Pages 1 and 2 sho.
Department of Health and M.
Important: If Item 27
any injury or " 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Vincent Civitarese, Son 46 Dungarrie Road, Baltimore, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Fntombment Parkwood Cemetery 04/02/2008 Baltimore Maryland 22. Name and Address of Facility 5305 Harrord Road ^{In}Baltimore Maryland 21214 21. Signature of Funeral Service Licensee lepandue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ischemia ardiac **Physician** unknow disease or condition resulting in death) /Medical Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 9□Unknown 5 Other (specify) the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed peen : 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy perform this certificate 20 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 Inpatient P 28a. Date of Injury (Month, Day Year) 27. Manner 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: the Funeral Director: After or Attending 5 ☐ Pending investigation 1 Vi atural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital To the Funeral within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier March 29,2008

10

Saltimore, Maryland 21215-0036

Vita

0

Division

State Registrar

lang 31. Date filed (Month, Day, Year)

and address of person who completed cause of death (Item 23a) (Type, Print) 900 Cakin

ORIGINAL

1marc, mD 21209

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Mard 2008 6 onal /Medical 4c. County of Death 4b. City, Towh, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Dundalk Baltimore Da nne Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 **□**M 2 □ F 220-30-6801 Yrs. Director 12,1934 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City. Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Dundalk 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21224 United States 955 Dalton Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 TYes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Wire Mechanic Western Electric Co. 8 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louise Baines Robert Orville Cassedy 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2015 Paulette Road Apt. 3 Dundalk, MD 21222 Patricia L. Balzano (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/29/2008 Oak Lawn Cemetery Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, DRG Dundalk, Maryland <u> 7922 Wise Ave.</u> Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) esd nech **Physician** takec years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it as a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Dav in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 □ Yes 2 □ No 9□Unknown 9 Tilnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 □Unknown 1 Tes 2□ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Extifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Oncology, 1650 Orleans St. 21231 Maltimore to ITAMMER

State Registrar 31. Date filed (Month, Day, Year)

2008

DHMH 17 Rev 1/2001

2. Registrar's Signature

08-02481 Fanny Chakedis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2	0	0	8	Polyantas	0	3	6	1

Пy	Charcus		1- For State	Oldio or .	Ce	rtificate	of Death			R	eg. No.	£ U (00
	Physicia		Registrar 1. Decedent's Name (F	First, Middle,Last)						Date of Dea Month	Day \	ear 3	3. Time of Death 1635 hrs	1
	Exami		Fanny	Chaked	lis					March 29	, 2008		10331113	
*			4a. Facility Name (if no	not institution, give stre	eet and number)			wn, or Location	ion of Death			ty of Death		1
			5329 Woodlot				Columi				Howa		(0)-1	_
	Euroral		5. Social Security Num	mber 6. Sex	7. Age (In yrs.	last birthda				8. Date of Bi	rth(MM/DD/YY	YY) 9. Birth Foreign	place (State or	
	Funeral Director		107-42-08	t	2X F 58		Yrs. Months	Days Ho	ours Min.	Mar. 1	10, 195		ntry) Sudan	
					2/1 30			11_						
	any		Usual Residence of D 10a. State	Ob. County	10c. Cit	y, Town or L	ocation				-		10d. Inside City Lim	
				Howard	Co-	lumbia							1 Yes 2 X	No
	Maryland 28a-f show d at once.	to			100		10f. Zip (Code			10g. Citizen of	What Count	ry?	
	Mary 28a d at	Director	10e. Street and Numb				210	11			USA			
	ith the Maryland 23a or 28a-f show notified at once.		5329 Wood		Title Book Lond Evenin	110 110	3. Was Deceden		Origin? (Spe	ecify Yes or N		ace - Americ	an Indian, Black,	
	h wit	Funeral	11. Marital Status 1 Never Married	-V	2. Was Decedent Ever in Armed Forces?	0.3.	If Yes, specify	Cuban, Mex	kican, Puerto F	Rican, etc.)	V	/hite, etc.		- 1
	deat or ite	F			Yes 2 X No		1 Yes 2	X No spe	ecify:		Spec	ify: Wh	ite	
	after ral", iner	_	3 Widowed	4 Divorced If Y	Dates: nighest grade completed)	160 Dec	redent's Heual (occupation (C	Give kind of w	ork done	16b. Kind o	f Business/Ir	ndustry	
	hours afte "natural", Examiner	p	15. Decedent's Edu		College (1-4 or 5+)	dur	ing most of work	ing life. DO I	NOT use retire	ed)				
Ç	n 72 n 72 ical	Completed	12	idaly (0-12)	3	Owne	er / Pre	sident	t		Arist	a Adv	ertising_	Inc
Š	withi jene.	E	17. Father's Name (F	First Middle Last\				18.M	lother's Name	(First, Middle	, Maiden Surn	ame)		
	Z1Z13-0030 suld be filed within 72 Mental Hygiene. marked other than ic event, the Medical	l Ö		s V. Mitze	lintis			019	ga Dim	itriou				
9	d be denta denta narke	e Be		me/Relationship (Type		19b. I	Mailing Address	(Street and	d Number or R	Rural Route N	lumber, City or	Town, State	, Zip Code)	ł
	shoul and N 7 is n	ľ	James Cha		husband	750	N. Tan	niami '	Trail :	#1409;	Saraso	ota, F	L 34236	
	DTE, INID 21219-0030 set 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f she ther traumatic event, the Medical Examiner must be notified at once ther traumatic event, the Medical Examiner.		20a. Method of Dispo		20	b. Place of I	Disposition (Nan	ne of cemeter	егу,	Date	20c. Loca	tion - City or	Town, State	1
	5 등 등 등 등 등 등 등 등 등 등 등 등 등 등 등 등 등 등 등		1 X Burial 2	Cremation 3	Removal from State		or other place) etrios Gre	ok Com	4/4	/08	Cub I	l ill,	MD	ŀ
	Pag ment tant:		4 Donation 5	Other Specify:		t. Delle	22. Name and			, 00	110	o Yor	k Road	
	Baltimore, IMD Z1Z15-0U30 permit. Pages I and 2 should be filed within 72 hours af Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural injury or other traumatic event, the Medical Examin	1	21. Signatu e TFun	ner e e Lisensee	5		Ruck To			1 Home	Tov	vson,	MD 21204	- 1
		-	23a Part Enter the	e disease, or complici	ations that caused the de	ath. Do not	enter the mode	of dying, such	h as cardiac o	r respiratory	arrest, shock,	or heart	Approximate Inte	
	ysicíar Jedica		failure. List only	lv. one cause of each	line. therosclerotic Card								Death	
	Examine		Immediate Cause (F or condition resultin	Title division	neroscierotic Card le to (or as a consequent		Diocase							
				h	io to to a consequent	,								
		à	Sequentially list con if any, leading to im	nmediate Du	ue to (or as a consequen	ce of):								
		1 2	cause. Enter Under (Disease or injury th	hat initiated	ue to (or as a consequen	re of):								
	الله الله	Evaminer	events resulting in o	death) Last d.	te to (or as a consequent	30 017.								
	ion of Vital Records, P.O. Box 68760, tending Physician: The law requires that the death certificate be executed leath.	2	UNPENDED		AMENDED									
	60, ate be exe hysician	Modical	ONPENDED		23c. If yes, outcome of	oregnancy					23d. D	ate of delive	ry	
	76 ficate g phy				1 Live birth	2	Fetal death	3 🔲	Ectopic pregn	ancy	Mo	nth	Day Year	ır
	Box 687 ne death certification the attending property of the p	1 1	past 12 months 1 Yes 2 V		4 Pregnant at time		Other (Spe	ecify)						1
	death death he att		n 1 Yes 2 ✔ N		9 Unknown				. D. d.l.	220 5	old tobacco USE	contribute t	o the cause of deat	th?
	O. I	בוקרות ב		ificant conditions	contributing to death but	not resulting	in the underlyin	g cause give	en in Fait i.				obably 4 Unkn	
	ires that the signed by the detach		<u> </u>								Vas an		autopsy findings ava	
	v requir		919							a	utopsy	prior to death?	completion of caus	se of
	COle law	7 2	ompieted								erformed? ′es 2 ✔ No			No
	tal Rection: The certificate	ै। ९	OF Mon case refer	rred to medical				26.Place of	f Death (Check	k only one)				
	ital Ician s cert		examiner?	Ho	ospital: 1 Inpatient	2 ER/OL	tpatient 3	DOA Ot	ther4 Nurs	sing Home 5	Residenc	e 6 🗸 Oth	er: Scene	
	Division of Vital Records, tal or Attending Physician: The law requirers after death.	ᇎᅡ	1 Yes 27. Manner of Dea	2 No	28a. Date of Injury	28b.	Time of Injury	28c. Injury a	at Work?	28d. Desc	ribe how injury	occurred		
	n o Iding h. Aff	e tuneral	Natural	5 Pending	(Month, Day,Year)			1 Yes	s 2 No					
	Sio	by th	2 Accident	Investigatio	28e Place of Injury	- At home, fa	rm, street, facto	ry, office buil	lding, etc.		ion (Street and wn, State)	Number or	Rural Route Numbe	er, City
	Divi	ed in	1 Natural 2 Accident 3 Suicide 4 Homicide	6 Could not b determined	e I					0110	wii, Otato)			
	Division To the Hospital or Attendivitin 24 hours after death. To the Funeral Director:			Certifying Physicis	an: To the best of my kno	wledge, dea	ath occurred at t	he time, date	e and place, at	nd due to the	cause(s) and	manner as s	tated.	
	the H in 24 the F	nplete	(Check only one) 2 ✓	Medical Examiner:	an: To the best of my kno On the basis of examina and manner stated.	tion and/or i	nvestigation, in	my opinion, d	death occurred	at the time,	date and piece	, and		
4	To with	con	29b. Signature and		and manner stated.			9c. License i	number		29d. Da	ate signed (/	Month, Day, Year)	
4			Tal	- 1	If win			O.C.M	I.E.		Marc	h 30, 200	8	
	1		Jan Harris	drope of person who c	completed cause of death	(Item 23a)		5						
	22			eenberg MD.	Assistant Medical E	xaminer	111 Penn	Street, B	Baltimore, N	MD 21201				
	O.	C to	31. Date filed (Mor	onth. Day, Year)	Registrar's S		diest)							
		Sta	rar A	PR 0 1 200		A P	The same of the sa							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of i	Marylan	•	artment of F			Re	g. No.	08	10364
Physici /Medi		1. Decedent's Name (First, Middle, WILLIAM)	J.CLANG					M	Date of Death Month ARC	Day H 30	Year ZOOS	3. Time of Death
Examir	ner	4a. Fecility Name (If not institution, Ellicott City 5. Social Security Number	Health & Re		ast birthday)	4b. City, Town, of Ellico	tt Cit	Y 24 Hrs. g i	Date of Birth	НС	ward 9. Births	olace (State or Foreign
Funeral Director		578-22-6124 Usual Residence of Decedent	1 ∑X M 2□F	8	38 Yrs.	Months Days	Hours	Min. (Month, Day, lg. 18,	Year) 1919	Wash:	ington, DC
the Marylan 28a-f show	ector	Maryland Howa: 10e. Street and Number	rd	10c. City	, Town or Lo				10	og. Citizen o		0d. Inside City Limits 1 ☐ Yes 2 ☒ No
with be or	ļ	11873 Bright Pa	ssage			2104	14		'	U.S.A		,
Baltimore, Maryland 21215-UU36 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other then "natural", or Items 23e or 28e-f show my njury or other traumatic event. I've Medicul Exaru and must be codified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 XWidowed 4 Divorced	12. Was Decede Armed Force	s? □ No		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	lispanic Orig an, Mexican,	gin? (Specify , Puerto Rica	Yes or No- an, etc.)	14. Ra	ace - Americ lack, White,	
21215-0036 od within 72 hours afl giana. ar then "natural", or tra Medical Exam.	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	s Education t grade completed) College (1-4-4-4-4-4-4-4-4-4-4-4-4-4-4-4-4-4-4-4	or 5+)	16a. Deced (Give life.	dent's Usual Occup kind of work done DO NOT use retire ntant	eation during most d)	of working		16b. Kind of		dustry s Company
Maryland 2 id 2 should be filed it the and Mental Hygic 27 is marked other traumatic event.	To Be Co	17. Father's Name (First, Middle, I						r's Name <i>(Fi</i>	irst, Middle, N			o company
re, Mary 1 and 2 sho 1 Health and h tam 27 is ma other traums		19a. Informant's Name/Relationsh Patrick Clancy 20a. Method of Disposition	(Son)	20b. P	1187	ng Address (Street 3 Bright sition (Name of patory or other pla	Passa		olumbia		21045	
Baltimore, permit. Pages 1 ar Deportment of Hea Important: If item any njury or other		1 ABurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service L	ecify)	Na:	tional	Cemeter	7 4	-16-20 Homes		Arling	ton,	Virginia
	1 //	23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cau	sed the death		Name and Addre 1TZKE Fur 555 Twin					MD 21	045 Approximate Interval Between
Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	aASP Due to (or bDue to (or	1 RAY	uence of):	PNEU	MONI	IA	. 1	000.07	200	Onset and Death
st 60, %	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	o. D1	A ITCL as a consequ ARE; as a consequ	TES	ME	Li7	105				monetrs
The Cords, F.O. Box ob 700, C. The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		n 2∏Feta tat time of d	Ideath 3□	□Ectopic pregnanc □ Other (<i>specify</i>) _	у			1	Date of deliv Month	ery D <i>a</i> y Year
rdS, F, quires that in signed by uld be deta		Part II. Other significant conditio	ns contributing to deat	h but not res	ulting in the u	nderlying cause gr	ven in Part I.	_]		oacco use co os 2 ☐ No		he cause of death?
VITAI KECOTGS, sician: The law requires I certificate has been signe irector, page 2 should be i	Completed			_					24a. Was an autops perform	y		opsy findings available impletion of cause of
Phy rall d	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Matural 5 Pendin.	28a. Date of		ER/Outpatier 28b. Time o Injury	f 28c. Inju Wo	ner: 4 Jur ry at rk?	rsing Home 28d	heck only on 5 Reside Describe ho	nce 6 🗆 C		(y)
Division To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Certification;	2 Accident investig 3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Place of	Injury - At ho , etc. (Specif	ome, farm, str	M 1	Yes 2□N		Location (St. City or Town		mber or Run	al Route Number,
ha Hospit in 24 hours ha Funera pletely fille	edical		g Physician: To the be Examiner: On the base and manne	est of my kno is of examina r stated.	wledge, deat tion and/or in	h occurred at the ti vestigation, in my	me, date and opinion, deat	d place, and th occurred a	due to the ca at the time, da	ause(s) and ate and plac	manner as s e, and due t	stated. o the cause(s)
Totl withi Totl	M	29b. Signature and title of certifier	bupler	10		29c. Licen:	os 3	150	2	9d. Date sign	ned (Month,	Day, Year) 2008
15/1		30. Name and address of person of Shawwa MA	who completed cause	of death (Item	23a) (Type,	Print) 5AN71A	60	ROA	o su	SUM	110 BIA	o the cause(s) Day, Year) 2008 4021045
Sta Regist	ate rar	31. Date filed (Month Pay Year)	2008	istrar's Signa	WI'B	3 de						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** Cohn OE 2005 1:55 M ISabor roch /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Worth was t 5. Social Security Number Herspittel Center | Real of Under 24 Hrs. | Months | Days | Hours | Min. | Boll more 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Director 212-22-4515 08 07/02/1927 MD Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show 1 □ Yes 2 PNo 7 is marked other than "natural", or items 23a or 28a-f st traumatic event, the Medical Examiner must be notified Director BALTIMORE REISTERSTOWN MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 5 WICKHAM COURT 21136 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: WHITE þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "I Elementary/Secondary (0-12) College (1-4or 5+) ELECTRICIAN ELECTRICAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ALEXANDER COHN DE BAER HELEN ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or other traun 5 WICKHAM COURT, REISTERSTOWN, MD 21136 HARRIET COHN / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State SHAAREI ZION CONG. 03/31/2008 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., May 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Uno Sepsus /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Truct Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-transit death certificate be executed Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical the as IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear Day 4□Pregnant at time of death 5 Other (specify) the 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 🔎 No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24a. Was an has autopsy performed? 1 Yes 2 No certificate funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ⊅ No **≱**☐ Inpatient 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred e Hospital or Attending P 24 hours after death. e Funeral Director; After t After t Certification: 5 ☐ Pending investigation Injury Natural 1 ☐ Yes 2 □ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 🗌 Homicide To the Hospital of within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number

Registrar

State

5401

Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

APR 0 1 2008

29085

Rago

COUNT

30

21133

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3 **Physician** Year 0 2008 220 M IARTHA 6 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death County of Death **Examiner** North west Randallstown i Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Days 430) Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday **Funeral** 1 □ M 2 F Director Usual Residence of Decedent death with the Maryland 10b. County r 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Windsor 1 ☐ Yes 2 ☐ No MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe of "natural", or items 23a o Funeral Was Decedent Ever in U.S. Armed Forces? American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or ite any Injury or other traumatic event, the Medical Examine. 1 Never Married 2 Married 1 ☐ Yes 2 No 3altimore, Maryland 21215-0036 δ. Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12)

A years

17. Father's Name (First, Middle, Last) College (1-4or 5+) Baltinure Cit 6 years 18. Mother's Name (First, Middle, Be MOSE, SIMMS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, Husband 1702 DMOX 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card or respiratory arrest, shock, or held failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician PRONTRY /Medical Due to (or as a consequence of): Examiner MASTENSION Sequentially list conditions Examiner day, leading to himself cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 9□Unknown 5 Other (specify) signed by the at d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \(\sum \) Nursing Home 1 Pes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Mannet of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation after death. 1 ☐ Yes 2 🗌 No 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 26/2008 30. Name and address of person who complet cause of death (Item 23a) (Type, Print) VIA

Registrar

APR 0 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fh 88784-9-08 vt. State of Maryland? Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 200 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1943 **Funeral** Months 1 M 2 □ F 212-40-3429 Usual Residence of Decedent Director filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ms 23a or 28a-f show must be notified at 1 ☐Xes 2 ☐ No Funeral Director 10g. Citizen of What Country? 10e. Street and Number USA 6402 11. Marital Status Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Pages 1 and 2 should be filed within 72 hours after deat nent of Health and Mental Hygiene.
ant; If Item 27 Is marked other than "natural", or items; uny or other traumatic event, the Medical Examiner nu runy or other traumatic event, the Medical Examiner nu Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🙀 No Black Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maide 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type. Print) WIFE) ramela Baltimore, 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Department o Important: If any Injury or once. 21. Signature of Funeral Service Licensee Rd. Balto ND 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical F FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4⊡Pregnant at time of death 5 Other (specify) P.0. ed by the a detached f 9□Unknown 9 ☐ Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 2X No 3 Probably 4 Unknown 1 TYes cate has been siç , page 2 should b 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate has 1∐ Yes **Division or Vital** 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: No No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tyes မှ this funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: within 24 hours after death. To the Funeral Director; After t Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide completely filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date flied (Month, Day, Year) APR 0 1 egistrar's Signature State 2008

DHMH 17 Rev 1/2001

Registrar

Division or Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

Funeral

Director

iral", or items 23a or 28a-f show Examiner must be notified at

"natural", or

Director

Funeral

ò

Completed

Be

MD

Pages 1 and 2 should be filed within 72 hours after death Health and Mental Hygiene. tem 27 is marked other than item 27 i 20a. Method of Disposition permit. Pages
Department of I
Important: if its
any injury or o
once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician Physician/Medical attending for use as IF FEMALE: 23b. Was decedent pregnant in the past 12 months? I ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 1 ☐ Yes 2 No P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Medical Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and fittle of certifier 29c. License number 29d. Date signed (Month, Day, Year) D2561 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) 78450akwood Rd#300 Glen Burne, Md Ira E. Kaplan 32 Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

APR 0

31/08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March 26, 2008 **Physician** 4:50 P M Alfonso Joseph DeLeonardis /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Upper Chesapeake Medical Center Bel Air | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Jan. 18, 1921 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 M 2 □ F Pennsylavania 87 202-22-7315 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County f show a or 28a-f show t be notified at 1 ☐ Yes 2 No Director Harford Bel Air Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21014 USA 706 Bedford Road "natural", or items 23a edical Examiner must b Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2XNo Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) pe mit. Pages 1 and 2 should be filed within Department of Health and Mental Hygene. Imnortant: If item 27 is marked other than an Injury or other trauma to event, the Me Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Chemical Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DeLeonardis Marco (unk) Concetta Maria Gallotti ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 706 Bedford Road, Bel Air, MD 21014 Elsie A. DeLeonardis/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Hilltop Service Corp: 4-1-08 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ture of Funeral Service Litensee 22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, Maryland 21014 23a. Part1. Enter the disease, or complications that caused the shock, or healt failure. List only one cause on each line. Do not enter the mode of dwng such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final ancer Marth **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury Due to (or as a consequence of): elected dis Alforso Maccostago Division or Vital Records, P.O. Box 68760, attending physician and for use as the burial-transit Exami that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ate has been signed by the atte page 2 should be detached for a Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 √nknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy 1□ Yes 2 1 No director. 25. Was case referred to medical examiner?

1 Yes 2 Ho 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA P To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral dir this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 27. Manner of Death (Month, Day Year) Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Lettifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my opinion death accurred at its own of the cause Medical 29a. Certifier dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and tit Name and address of person who completed cause of death (Item 23a) (Type, Print)

11 TAV. S. NAIR M.D., 602.S. Atword Rd. Belain MD 21014

31. Date filed (Month, Day, Year) State APR 01

2008

32. egistrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician Henry E. Dusold MARCH 30 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SAINT SAINT AGNES
Social Security Number TIMORE UOSFITA L 6. Sex If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Hours 1 M 2□F Days 321-05-8983 **Director** 90 2, **Illinois** 1917 Nov. Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County ral", or Items 23a or 28a-f shov Examiner must be notified at 1 ☐Yes 2 ☑No Maryland Director Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 715 Maiden Choice Lane PV211 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 □XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)
uperintendent of permit. Pages 1 and 2 should be filed within 72
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "in any Injury or other traumatic event, the Medis once. Elementary/Secondary (0-12) College (1-4or 5+) Superincence Disbursements Energy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry E. Dusold, Sr. May Fice 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Colette Dusold Wife 715 Maiden Choice Lane PV211; Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 3/31/2008 4 □ Donation Metro Crematory Catonsville, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of CatonsvIlle, Inc. 21. Signature of Funeral Service Lice 1630 Edmondson Avenue: Catonsville, MD 21228 23a. Part1. Enter the seease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PSIS **Physician** DAYS /Medical Due to (or as a consequence of): Examiner OBSTRUCTION DOWEL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine MUCINOUS OF COLON ADENOCARCINOMA physician ar s the burial-t Records, P.O. Box 68760 Physician/Medical attending p IF FFMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2☐No 3☐ Probably 4☐Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed certificate 2₽No 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA 9 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division (Month, Day Year) Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 18905 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ax1 CATON AVE, BALTIMORE, MD 900 MANISM

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 0

1

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

6810 Park Heights Avenue Apt. 308 Baltimore	Year	3. Time of Death 1742 hrs						
ALEXANUER JETNER March 26, 2008 4a. Facility Name (if not institution, give street and number) 6810 Park Heights Avenue Apt. 308 Funeral Director 7. Age (In yrs. last birthday) Months Days Hours Min.	8 c. County of Death	1742 hrs						
6810 Park Heights Avenue Apt. 308 Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1								
Director 213-88-62/6 Months Days Hours Min.	IN/A							
Director 213-88-6246 1X M 2 F 40 Yrs. Months Days Hours Min. 04/23/19	ate of Birth (MM/DD/YYYYY) 9. Birthplace (State or Foreign							
		untry) MD						
Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits						
B d D N/A D DALTTMODE		1 X Yes 2 No						
MD N/A BALTIMORE 10g. City 10g. Street and Number 6810 PARK HEIGHTS AVENUE, APT. 308 21215	tizen of What Cour	itry?						
PROPERTY OF THE PROPERTY OF TH	USA							
The state of the s	14. Race - Ameri White, etc.	ace - American Indian, Black, /hite, etc.						
The part of the pa	Specify:	WHITE						
3 Widowed 4 Divorced If Yes, Give Yeer or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 17b. Decedent's Education (Specify only highest grade completed) 18c. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 18c. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 18c. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 18c. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 18c. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 18c. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	Kind of Business/I	ndustry						
Elementary/Secondary (0-12) College (1-4 or 5+)	CINAT	0007741						
15. Decedent's Education (Specify Only highest grade completed) 16. Decedent's Education (Specify Only highest grade completed) 16. Decedent's Education (Specify Only highest grade completed) 16. Decedent's Education (Specify Only highest grade completed) 16. Decedent's Education (Specify Only highest grade completed) 16. Decedent's Education (Specify Only highest grade completed) 16. Decedent's Education (Specify Only highest grade completed) 16. Decedent's Education (Specify Only highest grade completed) 16. Decedent's Education (Specify Only highest grade completed) 16. Decedent's Education (Specify Only highest grade completed) 16. Decedent's Education (Specify Only highest grade completed) 16. Decedent's Education (Specify Only highest grade completed) 16. Decedent's Education (Specify Only highest grade completed) 16. Decedent's Education (Specify Only highest grade completed) 16. Decedent's Education (Specify Only highest grade completed) 16. Decedent's Education (Specify Only highest grade completed) 16. Decedent's Education (Specify Only highest grade completed) 16. Decedent's Education (Specify Only highest grade completed) 16. Decedent's Education (Specify Only highest grade completed) 16. Decedent's Education (Specify Only highest grade completed) 16. Decedent's Education (Specify Only highest grade completed) 16. Decedent's Education (Specify Only highest grade completed) 16. Decedent's Education (Specify Only highest grade completed) 16. Decedent's Education (Specify Only highest grade completed) 16. Decedent's Education (Specify Only highest grade completed) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maider)		<u>OSPITAL</u>						
지 열 등 현 등 ALBERT DEINER SHIRLEY		KWASTEL						
The state of the s	•	•						
20c Method of Disposition 20c Name of Computery Date 20c	Location - City or	MD 21136 Town, State						
201. Flate of Disposition Amuno Cong.	ALTIMODE	MD						
AMUNO CONG. 03/30/2008 B 4 Donation 5 Other Specify: 21. Sona are of Funeral Service Liberice 22. Name and Address of Facility SOL LEVINSON 8900 REISTERSTOWN ROAD - PIK	& BROS.	, INC.						
18900 REISTERSTOWN ROAD - PIK	ESVILLE,							
Physician We i al 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, she failure. List only one cause on each line.	nock, or nean	Between Onset and Death						
Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Cardiovascular Disease Due to (or as a consequence of):								
Sequentially list conditions, b								
if any, leading to immediate Due to (or as a consequence of): Cause. Enter Undanying Couse (Disease or injury that initiated Co								
িত্ত events resulting in death) Last Due to (or as a consequence of):								
OBLIGHT OF THE STATE OF THE STA								
	3d. Date of deliver	<u> </u>						
22. If yes, outcome of pregnancy 1	Month I	Day Year						
Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco								
1 See 1 letter that 2 letter t		the cause of death?						
24a. Was an autopsy	24b. Were au	itopsy findings available						
24a. Was an autopsy performed? 1 Yes 2 V 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Date of Injury 28d. Describe how in	? death?	completion of cause of						
Yes 2 ✓ 25. Was case referred to medical 26. Place of Death (Check only one) 27. Was case referred to medical 28. Place of Death (Check only one)	No 1 Y	es 2 No						
25. Was case referred to medical examiner? 1 Yes 2 No 100 Detail (Creek only only) 100 Detail (Creek only only) 100 Detail (Creek only only) 100 Detail (Creek only only) 100 Detail (Creek only only) 100 Detail (Creek only only) 100 Detail (Creek only only)	dence 6 🗸 Othe	r: Scene						
THE SECOND SECON	njury occurred							
Volume 1	and Number or Ri	ural Route Number, City						
O U Silva La La La La La La La La La La La La La		Tar Notice Named, Only						
29a. Certifier 1								
	d. Date signed <i>(Mo</i> arch 27, 2008	nni, Day, i ea j						
30. Name and address of person who completed cause of death (Item 23a)	97001. W							
Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201								
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / De	partment of F ertificate of			iene _{eg. No.} 2 1 1 8	10372
			1. Decedent's Name (First, Middle, Last)			2. Date of Death	h	3. Time of Death
	Physicia		Henry Robert Emge		I	March 2	29 ^{Day} 2008 ^{ear}	9:10p м
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, c	or Location of Death		4c. County of Death	
and the same			Gilchrist Center	Tows		10:11	Baltim	
	Funeral Director		5. Social Security Number 2 1 2 − 4 0 − 6 1 7 4		Hours Min.	8. Date of Birth Dec 109	, Y 1 9 41 O	nplace (State or Foreign untry) MD
-	Ö		Usual Residence of Decedent					10d. Inside City Limits
	arylan show	ž	10a. State 10b. County 10c. City, Town or MD Baltimore Middl	e River				1 ☐ Yes 2 No
:	the M	rect	10e. Street and Number	10f. Zip Code		11	0g. Citizen of What Co	untry?
3	n with	al Di	20 Compass Road	21	220		USA	
950	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: I flem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventiment in the conce.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ № 2 2 ☐ No If Yes, Give Year or Dates:	3. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 🔀 No	an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
5	2 hou latura lcal E	ted		ecedent's Usual Occu ive kind of work done	pation		16b. Kind of Business/	Industry
7	ithin 7 ne. nan "n	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	e. DO NOT use retire	nd)		Ho-Ro Tr	ucking
7	lled w Hygier ther th		12th 17. Father's Name (First, Middle, Last)	- DIIVE	18. Mother's Name	(First, Middle, N	Maiden Surname)	· · · · · · · · · · · · · · · · · · ·
	d be f ental I ked of ic eve	To Be	Isaac Emge		Mommie		_	
ary	shoul and M s mar tumati	۲					; City or Town, State, 2	
∑ .	and 2 ealth m 27 i						re MD 212	
allillore	Pages 1 ment of H ant: If Iter ury or oth		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Bayvi	sposition (Name of crematory or other place EW Crema	fory 3/3	1/08	Baltimor	e MD
	permit. Depart Import any inj		21. Sign for re of Fineral Service Learnee	22. Name and Address Connell	y Funera	1 Home	Avenue E of Essex	
	hysician /Medical		23a. Part 1. Enter the disease, or conditionations that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	enter the mode of dy	ing, such as cardiac o	or respiratory arr	est,	Approximate Interval Between Onset and Death Mon Ph S
	Examiner							
	© 1 \ Æ	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					
	and A	Examiner	Cause (Disease or injury that initiated events resulting in death) Last					
9/00/	icate be executed physician and street the purial-transit	dical E						
90	tificate ig phy as the	ledic		11/2				
O. BOX	ding Physician: The law requires that the death certificate be executed n. h. After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnan 5 ☐ Other (specify)	icy		23d. Date of de Month	livery Day Year
7.	s that t ned by e detad		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause g	iven in Part I.	23e. Did to	bacco use contribute to	the cause of death?
ecords,	en sig	ed by			<u> </u>	1 🗆 Ye	es 2 □ No 3 □ P	robably 4 Unknown
Hecc	The law re ate has be page 2 sho	Completed			.	24a. Was a autops perfori 1 ∐Yes	sy prior to med? death?	utopsy findings available completion of cause of
VITA	cian: ertifica ector, I	Be C	25. Was case referred to medical examiner?		26. Place of Deat			14.04.3
6	Physi this c ral dire	<u>۴</u>	1	allerit 3 DOA			ence 6 (Specifier (Specifier)	ecity) TOSPIC
5	iding th. : After : funer	tion	1 Natural 5 Pending (Month, Day, Year) Inju	ry Wo	ork? □Yes 2⊡No		•••••	
DIVISION	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director;	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office		28f. Location (S City or Town	treet and Number or R n, State)	ural Route Number,
	e Hospita 124 hours e Funeral iletely fille	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, and manner stated.	leath occurred at the or investigation, in my	time, date and place, opinion, death occur	, and due to the or red at the time, o	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To th Vithir To th COMP	Me	29b. Signature and title of certifier	29c. Licer	nse number		29d. Date signed (Mon	
	1		pron / Slas hub		61199		March, 30	1008
	10		30. Name and address of person who completed cause of death (Item 23a) (To Tasca Black 16565 North Charles	pe, Print)	to 2019.	To6-50	m) 212	204
	Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	4				
	Registi		APR 0 1 2008	berte	·			

DHMH 17 Rev 1/2001

March 29,2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 Fackett March 27 6:37 Louise P 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Gilchrist Center Towson Birthplace (State or Foreign Country)
 Maryland 8. Date of Birth (Month, Day, Year) November 30, 1936 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 X F Months Days Hours 212-34-5709 71 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Maryland Baltimore Edgemere 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21219 7523 Iroquois Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 XNo Specify Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Johns Hopkins Elementary/Secondary (0-12) College (1-4or 5+) Orthopedics 12 years Administrative Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) David Hafer Louise Newberger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21219 Husband 7523 Iroquois Avenue, Edgemere, Maryland Joseph Fackett Sr. 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sacred Heart Of Jesus 20c. Location - City or Town, State Dundalk, Md. 2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Fart 1. Enter the disea e. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death MULTIPLE MYELOMA Immediate Cause (Final YEARS disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lor as a consequence of Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 MOther (Specify) HDSPICE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

Completed by

P

Funeral

Director

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

68760.

o

σ,

Records,

Vital

ð

Division

Mari

avch

od 2 should be filed within 72 hours after death with the Marylan Ith and Mertal Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, it is Mydical Event in must be marked.

Health tem 27 I

permit. Pages 1 and Department of Healt Important: If Item 27 any Injury or other 1 once.

law requires that the death certificate be executed and burial-tran attending physician the as use cate has been signed by the attr page 2 should be detached for certificate Hospital or Attending

Examine Physician/Medical Be Completed by Medical Certification: To After this funeral 24 hours after death the

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 9 Unknown

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and

5 Pending investigation

6 Could not be

determined

28c. Injury at Work?

29d. Date signed (Month, Day, Year) MARCH 27,2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day, Year)

and manner stated

6565 N CHAPLES ST, SUITE 209 DANIEUE DOBERMAN, MO

2. Registrar's Signature

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

BALTIMOREIMO 21204

State Registrar

0

within 24 hours after devanther To the Funeral Directo completely filled in by the

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day FREEMAN **Physician** MARY 08 /Medical 4a. Facility Name (If not institution, give street and number) County of Death 4b. City, Town, or Location of Death Examiner JOHNS HOPKINS BAYVIEW MED. CTR MS ISHLTIMORE 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 🗆 M Director ibena Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural" or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at altimore 1 ☐¥es 2 ☐ No Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number alau Funeral Was Decedent Ever Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married 1 ☐ Yes 2 ☐ Ho If Yes, Give Year or Dates: altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a, Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be Esthor Williams treeman ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health at Important: If item 27 is any Injury or other traconce. Chatford Ave Baltimore, NAD 2/206 (Name of Date 20c. Location - City or Town, State Frances Draughon 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4.05.2008 Bailimore, MI 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Vaughm C. Jhoono 22. Name and Address of acility Vayan C. Greere Fireral Services 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4905 York and Baltimore MN 21212 CARDIAR FAIWRE Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** MARKETES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) P.O. Box 68760, physician the attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 Ø No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown signed by be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by HYPERTENSION 1 Yes 2 No 3 Probably 4 Onknown CHRONIC RENAL FAILURE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No After this certificate has funeral director, page 2 s autopsy Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 □ DOA 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

5

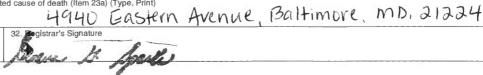
State ³¹ Registrar

31. Date filed (Month, Day, Year)

6. Galetto

APR 0 1 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



ORIGINAL

DHMH 17 Rev 1/2001

08-02306

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Kenneth Ford 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ Month Day March 23, 2008 Year Kenneth D. Ford 1717 hrs **Medical Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** 1 X M 2 F 7-5-1948 Months Hours Min. 216-52-4597 59 Davs Director Country) Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location any 1 Yes 2 No Baltimore City Md. 28a-f show must be notified at once, the Maryland rector 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country ā 7759 Wynbrook 21224 23а Funeral 14. Race - American Indian, Black, 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) death 1 Never Married 2 Married Yes 9 4 X Divorced rmit. Pages 1 and 2 should be filed within 72 hours after epartment of Health and Mental Hygiene.
nportant: If item 27 is marked other than "natural", to jury or other traumatic event, the Medical Examiner 1 Yes 2 No specify: Widowed f Yes Give Year Specify. White þ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 Construction 8th Carpenter 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Laura Shipley Nearmon E. Ford Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7759 Wynbrook RD. Son David Ford, Sr. 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a, Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State 4-1-2008 Balto. Md. Bayview Crematory 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd an 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a, Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical UNPENDED **AMENDED** attending physician for use as the burial Box 68760 23d. Date of delivery IF FEMALE 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. ģ 1 Yes 2 No 3 Probably 4 ✔ Unknown Chronic Ethanolism Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? . death? ✓ Yes 2 ✓ Yes 2 No the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certifit appletely filled in by the funeral director, p 25. Was case referred to medical 26.Place of Death (Check only one Division of Vital Be examiner? Other 4 Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 Yes 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death Certification: 1 V Natural Yes 2 No Director: d in by the f Pending 2 Accident Investigation 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** within 2. To the F 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. March 24, 2008 30. Name and address of person who completed cause of death (Item 23a)

State

Registra

Ana Rubio MD Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

32. Registrar's Signature Collins !

ORIGINAL

Division or Vital Records, P.O. Box 68760,

requires that the death certificate be executed Director

1 and 2 should be filed within 72 hours after death with the Maryland

3altimore, Maryland 21215-0036

within 24 hours a

completely 7

Medical

State

Registrar

2008

APR 01

31. Date filed (Month, Day, Year)

1 Yes 2 No 9 Unknown	4□Pregnant at time of death 5□ Othe	er (speciny)						
Part II. Other significant conditions of	contributing to death but not resulting in the underly	ing cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown					
			24a. Was an autopsy performed? 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No					
25. Was case referred to medical examiner?		26. Place of Dea	th (Check only one)					
1 Yes 2 No	Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐	□ DOA Other: 4 □ Nursing H	ome 5 ☐ Residence 6 ☐ Other (Specify)					
27. Manner of Death Natural 5 ☐ Pending 2☐ Accident investigation		28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred					
3 ☐ Suicide 6 ☐ Could not be determined		actory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	nysician: To the best of my knowledge, death occuminer: On the basis of examination and/or investig and manner stated.		e, and due to the cause(s) and manner as stated. arred at the time, date and place, and due to the cause(s)					
29b. Signature and title of certifier		29c. License number	29d. Date signed (Month, Day, Year)					
· Jsavæge		RES-000	March 27, 2008					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JESSICA Savage MD 4940 Eastern Avenue, Baltimore, MD, 21224								

32 Registrar's Signature

08-02341 Time

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Mandand / Department of Health and Mental Hydiene

2008 10377

Timothy L Foor	State of Maryland / De	partment of Health and Mental ertificate of Death	Reg. No.	0 1037
	- For State Registrar 1. Decedent's Name (First, Middle,Last)	ertificate of Bodin	2 Date of Death 3. T	ime of Death
Physician/ Examiner	Timothy L. Foor, Sr.		March 24, 2008	1559 hrs
4	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of De Halethorpe	Baltimore County	
	4503 Maple Avenue 5 Social Security Number 6. Sex 7. Age (In ye	rs. last birthday) If Under 1 Year If Under 24	Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthpla	ice (State or
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yr 213-68-5088 X M 2 F 51	Months Days Hours I		y) MD
Birestor	Head Residence of Decedent		100	d. Inside City Limits
any	10a. State 10b. County 10c. 0	City, Town or Location Halethorpe		Yes 2 X No
and f show	MD Baltimore	10f. Zip Code	10g. Citizen of What Country	?
he Maryland to 28a-f shriffed at once	10e. Street and Number	21227	USA	
ral D	4503 Maple Ave. 11. Marital Status 12. Was Decedent Ever	in U.S. 13. Was Decedent of Hispanic Origin?	(Specify Yes or No- perto Rican, etc.) 14. Race - American White, etc.	Indian, Black,
r death with or items 23 must be no	1 Never Married 2 Married Armed Forces?	No 1 Yes 2 X No specify:	Specify: Whit	
after or all., o liner n	3 Widowed 4 X Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade complete	a) Lace Decedent's Usual Occupation (Give king	d of work done 16b. Kind of Business/Indu	
"natu	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use	e retired)	
5-0036 ed within 72 hours after fygiene. Other than "natural" the Medical Examine Completed by	12	Machine Operator	Book Bindir Name (First, Middle, Maiden Surname)	1g
5-0(lled wi Hygier Jother The N	17. Father's Name (First, Middle, Last) Donald Foor	Doris	Ritchey	
2121; ould be fill d Mental F s marked lic event,	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number	er or Rural Route Number, City or Town, State, Z	(ip Code)
AD 2 show h and 1 27 is 1	Jason Foor, son	400 Darlene Ave. 20b. Place of Disposition (Name of cemetery,	Linthicum, MD. 21090 Date 20c. Location - City or To	own, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 33a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State	crematory or other place) West Arundel Crematory		MD I
Page ment o	4 Donation 5 Other Specify:	22. Name and Address of Eacility Ambrose Fune		
Balt permit Depart Impor injury	21. Signature of Funeral Service Licensee	Ambrose rune	rai nome, inc. <u>Spring Rd. Arbutus,</u>	MD 21227 Approximate Interval
յ ^{ր ∿} Կysician	233. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.	death. Do not enter the mode of dying, such as car	diac or respiratory arrest, shock, or heart	Between Onset and Death
ledical _xaminer	Immediate Cause (Final disease a. Hypertensive	atherosclrotic cardiovascular	disease	
Lammer	or condition resulting in death) Due to (or as a consequence)	ence of):		
	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of the consequence).	ence of):		
ed nsit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the consequence of	ence of):		
E [E E E	d			
[s s s	X unpended X amenaea, 24a, 2	27, perME, g879 5/13/08 TT	23d. Date of delivery	
Box 68760, cleath certificate be exerthe attending physician a for use as the burial -	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome 1 Live birth	2 Fetal death 3 Ectopic	pregnancy Month D	ay Year
cox 68 eath cert cert for use a	F FEMALE: 23c. If yes, outcome 23c. If yes, outcome 1 Live birth 4 Pregnant at tirr 1 Yes 2 No 9 Unknown 9 Unknown	ne of death 5 Other (Specify)		
the dea		ut not resulting in the underlying cause given in Pa	rt I. 23e. Did tobacco use contribute to t	
cords, P.O. B law requires that the de has been signed by the standard of the detached	â		Ode Wee en 12th Were all	tonsy findings available
rds, requir been s			autopsy prior to c	completion of cause of
eco he law ate has			1 Yes 2 No 1 Ye	es 2 No
al R	25. Was case referred to medical	26.Place of Death 2 ER/Outpatient 3 DOA Other	Nursing Home 5 Residence 6 Other	r: Scene
Division of Vital Records, P.O. pital or Attending Physician: The law requires that the ours after death. eral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach	O 1 ✓ Yes 2 No	2 ER/Outpatient 3 Box		
n of nding I th.	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day,Yea	1 163 2		S. ata Niverbox City
Division to Attendii rrs after death.	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Inju	ry - At home, farm, street, factory, office building, et	tc. 28f. Location (Street and Number or Ru or Town, State)	ural Route Number, City
Division Hospital or Attend 24 hours after death Finneral Director: etely filled in by the	determined (Specify)	to the fire data and pl	ace, and due to the cause(s) and manner as star	ted.
Hos 24 h Fun		knowledge, death occurred at the time, date and pl ination and/or investigation, in my opinion, death oc		
To the within To the complet	(Check only one) 2 Medical Examiner: On the basis of exam and manner stated.	29c. License number	. 29d. Date signed (IVIC	Still, Day, I car,
	Why.	O.C.M.E.	March 25, 2008	
	30. Name and address of person who completed cause of de	ner 111 Penn Street, Baltimore, MD	21201	
	David Fowler M.D. Chief Medical Examin	la Ciameturo		
St Regist	ate 31. Date filed (Month, Day, Year) 32 Registrar			

Registrar

08-02356 Ma

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ary E. Fries		State of Maryland / Department of Health and I For State Certificate of Death	Mental Hyg	jiene Reg.	No. 21	108 1037
Physicia	n/	egistrar . Decedent's Name (First, Middle,Last)		Date of Death Month	Day Year	3. Time of Death 0851 hrs
ledical Examin		MARY ELIZABETH FRIES 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Loc		March 25, 2	4c. County of I	
		Northwest Regional Hospital Randallstwon			Baltimore	
Funeral	1	3. Coold Scoulty Hamber		8. Date of Birth	(MM/DD/YYYY)	9. Birthplace (State or Foreign Country)
Director	2	205-28-8517 1 M 2x F 69 Yrs. Months Days	Hours Min.	May 13	, 1938	Worth Carolina
,	_	Jsual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
iow any		Maryland Baltimore Baltimore				1 Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number 10f. Zip Code		10g	. Citizen of What	Country?
the Ma a or 2		6950 Rockfields Road 21244			USA	
0036 within 72 hours after death with the Maryland giene. her than "natural", or items 23a or 28a-f sho Medical Examiner must be notified at once.	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispar 14. Never Married 2 Married Armed Forces? 15. Was Decedent of Hispar 16. Armed Forces?			14. Race - White,	American Indian, Black, etc.
	튑	1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 No 1 No 1 No 1 No 1 No 1 No 1 No	snecify:		Specify:	Black
urs afte	핡	or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation	(Give kind of wo		16b. Kind of Busi	ness/Industry
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. D	O NOT use retire	a)		
within riene.	틹	4 Administrator 17. Father's Name (First, Middle, Last) 18.	.Mother's Name (First Middle Ma		overnment
다 글 찾을 취	Be		Julia Be			?
	리	19a. Informant's Name/Relationship (Type, Print) Michael Garfield Fries / Son 3504 Cokesbury	and Number or Ru	ral Route Numb	per, City or Town,	State, Zip Code)
MD and 2 sho alth and 2 is raumati		Michael Garfield Fries / Son 3504 Cokesburg 20a. Method of Disposition 20b. Place of Disposition (Name of ceme		Date		City or Town, State
Baltimore, I permit. Pages I and Department of Heal Important: If item		1 Number Burial 2 Cremation 3 Removal from State crematory or other place)			- 1'	36
Baltimo permit. Page Department of Important: injury or oth		4 Donation 5 Other Specify: Darlington Cemeter 1 Ingrature of Funeral Service Licensee 22 McCollias Turney and Address of McCollias Turney and McCollias Tur				oton, Maryland
Balti permit. Departi Import injury	11	1317 Cokes	hury Roa	d. Abir	adon. Ma	aryland 21009
Physician		23a. Part i Enter the disease, or complications that caused the death. Do not enter the mode of dying, st failure. List only one cause on each line.	uch as cardiac or	respiratory arre	st, shock, o r hea r	t Approximate Interval Between Onset and Death
Fxaminer	1	Immediate Cause (Final disease or condition resulting in death) a. Complications of Metastatic Malignant Neoplasm Due to (or as a consequence of):				Beauti
		Sequentially list conditions, b				
	ine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				
/ 7 5	Examine	(Disease or injury that initiated events resulting in death) Last				
50, e be executed ysician and burial - transit	edical E	d d AMENDED		· ·		
50, te be e nysicial		IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of o	delivery
687(ertifica ding pl	an/N	23b. Was decedent pregnant in the past 12 months?	Ectopic pregnar	псу	Month	Day Year
Box 6876(e death certificate the attending phy. ed for use as the b	Physician/M	4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 ✓ No 9 Unknown g Unknown	-			
i, P.O. Boires that the designed by the	Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	ven in Part I.			oute to the cause of death?
ires the signed	d by				2 No 3	Probably 4 Unknown Vere autopsy findings available
ords w requ	plete			24a. Was a autop: perfor	sy p	rior to completion of cause of eath?
tal Reco tian: The law certificate has	Completed			1 🗸 Yes		Yes 2 No
ital ician: s certif rector,	Be	examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA	of Death (Check of Dither Nursing		Residence 6	Other:
of Vil ing Physic After this uneral dire	<u>1</u>	1 ✓ Yes 2 No 28a. Date of Injury 28b. Time of Injury 28c. Injury			now injury occurre	ed
OD (tending sath. or: Af	tion	2 Assident Investigation	es 2 No			
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the ras after death. **Al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office bu	ilding, etc.	28f. Location (S or Town, S		er or Rural Route Number, City
D ospital hours uneral y fillec		4 Homicide determined (Specify) 29a. Certifier Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date	e and place and	due to the caus	e(s) and manner	as stated.
Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion,	death occurred a	t the time, date	and place, and d	ue to the cause(s)
To with Con	Mec	29b. Signature and title of certifier 29c. License			29d. Date signe	ed (Month, Day, Year)
		Mhn. Brassel MY > O.C.N	1.E.		March 26,	2008
6		30. Name and address of person who completed cause of death (Item 23a)	altimore MD	21201		
_		24 Date filed (Month Day Veer) 32 Registrar's Signature	and more, IVID			
Regis	tate trar	APR 0 1 2008 Reserve & Aparles				

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

08-02279 Dominic Faw

M

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

minic Faw		Sta 1- For State	ate of Maryla		rtment of <i>tificate of</i>		and	Mental	l Hyg			200	1.2	1037
Physicia	_	Registrar 1. Decedent's Name (First, Middl	e,Last)		tinoute or	Douth		•	2.	Date of Dea		<u> </u>	3. Time o	of Death
edical Exami		Dominic Faw								Month March 22	, 2008	Year	2145	hrs
		4a. Facility Name (if not institutio University Hospital	n, give street and n	umber)	4	b. City, Tov Baltimo	, .	cation of D	eath		4c.	County of Deat	th	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. Ia	ast birthday)	If Under		If Under 2	_	8. Date of B	irth(MM/I	DD/YYYY) 9. Bi Forei		tate or
Director		219-98-9532	1 X M 2 F		2.8 Yrs.	Months	Days	Hours	Min.	08/1	7/1		ountry)	MD
any		Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Locati	on		-					10d Insi	de City Limits
≱		MD		100.013,	Town or Lood!		Ralt	imor						es 2 No
larylan 8a-f si at one	Director	10e. Street and Number	<u></u> .			10f. Zip C		LINOI	. e	- [10g. Citiz	zen of What Co	untry?	
the Man 2		2646 W. Frank	lin Str	eet			2	21223	3			USA		
death with the Maryland or items 23a or 28a-f show must be notified at once.	Funeral	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No									0-	n, Black,		
er dea											White, etc. Black Specify:			
ours afi atural	d by	15. Decedent's Education (Spec	or Dates:		16a. Deceden	t's Usual Od	ccupation	n (Give kin				Kind of Business	/Industry	
6 n 72 hc an "ns	Completed	Elementary/Secondary (0-12) 1 0	College (1-4 or 5+)		ost of working	ng lite. D	O NOT us	e retired	1)		_		Ì
-003 I withii giene, her th	mo	17. Father's Name (First, Middle,	Last)		stu	dent	118	Mother's N	Name (F	First, Middle	Maiden	schoo	1	
Baltimore, MD 21215-0036 germit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene. Importment of Health and Mental Hygiene. Importment If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Lyaminer must be notified at once.	BeC	Marcus McNea							•	Maria		,		
D 21 should nd Mer is mar	ပ	19a. Informant's Name/Relations Maria Chase		r								ity or Town, Star		e) 2 1 2 2 3
and 2 sho ealth and tem 27 is traumati		20a. Method of Disposition			Place of Dispos					Date		Location - City of	_	
Baltimore, permit. Pages I ar Department of Her Important: If ite		1 Burial 2 X Cremation			crematory or oth		orv	. 3	127	7/200	8 C. a	tonsvi	110	MD
altin mit. P. partme portan ury or		4 Donation 5 Other Sμ 21. Signatule of Funeral Service				lame and A	-					ral Ho		
W FQ III		Livela	Jones	25	6	38 N. G	ilmor	Stree	et: E	Baltimo:	re. M	D 21217		
Physician /Medical		23a. Part I. Enter the disease, or failure. List only one cause	on each line.				dying, sı	uch as card	tiac or r	espiratory a	rrest, sho	ock, or heart		imate Interval en Onset and Death
kaminer		Immediate Cause (Final disease or condition resulting in death)		ounds with co		8	_	_	_				-	Death
		Sequentially list conditions,	b											
	Examine	if any, leading to immediate cause. Enter Universitying Cause (Disease or injury that initiated	C. Due to (or as	a consequence o	of):									
uted d	Exa	events resulting in death) Last	Due to (or as	a consequence o	of):									
50, te be executed ysician and burial - transit	dical	UNPENDED	AMENDED											
3760 ificate	n/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes	, outcome of preg		tal death	3	Ectopic p	regnand	CV.	23	d. Date of delive	ery Day	Year
Box 6876 e death certificate the attending phy ed for use as the b	sician/M	past 12 months? 1 Yes 2 No 9 Uni	4 Preg	nant at time of de	oth -	her (Specif							,	
). BC the des	Phys	Part II. Other significant condit	19OUKI		esulting in the I	ınderivina c	ause niv	en in Part		23e. Did	tobacco	use contribute t	to the cause	e of death?
s, P.O. Be irres that the de signed by the d be detached the	þ		oona oo	10 40411 241 1101	5551111g 117 ti 10 C		auto g.v				-	No 3 Pr		
ords, w requir is been s should	Completed									24a. Wa	s an			dings available n of cause of
tal Reco cian: The law certificate has	dwo				-					per	formed?	death?	?	2 No
Vital Recysician: The his certificate director, page	BeC	25. Was case referred to medica examiner?					-10	f Death (C						
f Vid	ို	1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1	Inpatient 2	ER/Outpatient 28b. Time of I	lanara 4	^	ther ₄ .		Home 5		ence 6 Oth	ner:	
Division of Vital Records, tal or Attending Physician: The law require is after death: al Director: After this certificate has been sited in by the funeral director, page 2 should be	Certification:	27. Manner of Death 28a. Date of Injury Oct 1, 1939, Year) 28b. Time of Injury 0116 hrs 28c. Injury at Work? 1 Yes 2 No Subject shot												
ivision or Attenualter death Director:	ifica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number or Town, State)									Number, City			
Divisior ospital or Attend hours after death meral Director:	Sert	4 W Homicide determined (Specify) Street N. Eutaw Street and W. Saratoga Street, Baltimore, MD 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									altimore, MD			
Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the t	Medical	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
To To	Me										Year)			
		Theoden Mi.	Mer 8.	The w	us.		O.C.M	.E.	OCM	E	Ма	rch 23, 2008	3	
2		30. Name and address of person	•			111 Do-	n Ctro	et Rolf:	more	MD 212	n1			
	ate	Theodore M. King, Jr. 31. Date filed (Month, Day Year)		ant Medical l	ure		ııı əlre	et, Daill	more,	IVIU Z IZ	U 1			
Regis		31. Date filed (Month, Day Year)	1 2008	Elolus	K A	all?								

08-02374

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Connie Green 1- For State Certificate of Death Registra 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day March 25, 2008 2110 hrs Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Maryland General Hospital Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Country) Months Hours Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No 28a-f show Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral 11. Mantal Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Was Decedent Ever in U.S. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc Armed Forces? Yes Pages I and 2 should be filed within 72 hours after 4 Divorced If Yes, Give Year 1 Yes 2 No specify: 3 Widowed Specify à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Flementary/Secondary (0-12) College (1-4 or 5+) d other than " timore, MD 21215-0036 nt of Health and Mental Hygiene. It item 27 is marked other th other traumatic event, the Medi 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be 2 (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 2 Cremation 3 Removal from State tant: Other Specify Donation Name and Address of Facility 23a Part / Enter the disease, or complications that caused the death. Do not enter the Approximate Interval mode of dying, such as cardiac or respiratory Physician List only one cause on each line. Between Onset and /Medical Death a Atherosclerotic Cardiovascular Disease e Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and The law requires that the death certificate be execu-Physician/Medical by the attending physician ached for use as the burial -UNPENDED **AMENDED** Box 68760, IF FFMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. ò 1 Yes 2 No 3 Probably 4 V Unknown Completed this certificate has been a director, page 2 should 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? Yes 2 No Vac 2 No 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be Hospital: 1 Other: Other: Inpatient 2 V ER/Outpatient DOA Nursing Home 5 Residence 6 1 V Yes No 28a. Date of Injury (Month, Day,Year) After 1 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Certification: n 24 hours after death.

The Funeral Director: A pletely filled in by the fu 1 V Natural 5 Pending 1 Yes 2 No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 26, 2008 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 0 2008 Registrar

DHMH 17 Rev 1/2001 OCME 2006

State Registrar BRIAN

31. Date filed (Month, Day, Year)

GARIBALDI

MD

32, Registrar's Signature

DHMH 17 Rev 1/2001

08-02402 Wayne Geiger Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 10382

			1- For State Registrar		Certi	ificate of	Death				R	eg. No.			
	Physicia	_	Decedent's Name (First, Middle)	e,Last)							Date of Dea	ith	Veer	3.	Time of Death
	al Exami	ner	Wayne			Geige	er			1	Month March 26	, 2008	Year		2037 hrs
			4a. Facility Name (if not institution	n, give street and no	umber)		o. City, Tow	n, or Lo	cation of				ounty of De	eath	
			Good Samaritan Hosp	ital			Baltimo	re							
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. las	t birthday)	If Under 1	Year	If Under	24Hrs.	8. Date of Bi	rth(MM/DD/	YYYY) 9.	Birthp	lace (State or
	Director		216-86-4864	.17		10	Months	Days	Hours	1.7	April	,	l Fo	reign	Maryland
		L		1X M 2 F		46 Yrs.				<u> </u>	WDITT	3,150		Count	wiai y land
	ž.	- }	Usual Residence of Decedent 10a. State 10b. County		Inc. City T	own or Location								1/1/	Od. Inside City Limits
	w any		,		1										X Yes 2 No
	daryland 28a-f show 1 at once.	ō	Maryland N/A	1		Baltim	ore								
	Mary 28a-	eC.	10e. Street and Number				10f. Zip Co	ode				10g. Citizen	of What 0	Country	?
	the ya or	Funeral Director	4802 Richard Av	enue			2	2121	4			Ü	JSA		
	with ns 23	<u>ra</u>	11. Marital Status	12. Was De	cedent Ever in U.S.						ify Yes or N	0- 14.			n Indian, Black,
	leath riten	au nu	1 Never Married 2 X M	arried Armed F	orces?	If Ye	s, specify (Cuban, N	Mexican, f	Puerto Ri	can, etc.)	1	White, et	tc.	
)	fler d		3 Widowed 4 Div	orced If Yes, Give Ye		1	Yes 2X	No	specify:			Spe	ecity: W	hit	e
0	urs a tura	d by	15. Decedent's Education (Spe	cify only highest gra	de completed)	16a. Decedent						16b. Kind	of Busine	ess/Ind	ustry
\	72 ho	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during mo	st of workin	g life. D	OO NOT u	ise retired	1)				
\	hin 7	희	12 years			Maint	ence V	vork	er			Cor	ndomi	niu	m
	d will	팃	17. Father's Name (First, Middle	, Last)				18	.Mother's	Name (F	irst, Middle,	Maiden Su	rname)		
	e file		Louis Geiger					1 -	orot	hv A	bbott				
	21215-0036 nuld be filed within 7 Mental Hygiene. marked other than c event, the Medica	100	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailing	Address					mber, City o	or Town, S	State, Z	ip Code)
	MD d 2 sho Ith and n 27 is numati		Denise Geiger	TA7 -	ife	4802	Richa	rd A	venu	e. B	altimo	ore. M	Marvl	and	21214
	and and sealth tem	ł	20a. Method of Disposition	**.		ace of Disposi							ation - Cit		
	Ore of H		1 X Burial 2 Cremation	n 3 Removal f	TOTT OLATE	ematory or oth		~			h 31,	_	7 71		1
	Pag ment tant:		4 Donation 5 Other S	pecify:	Sacre	ed Heart					800				yland
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injuyy or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	Signature of Funeral Service Lidensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P. 7110 Soilers Point Road, Dundalk, M.										.A.	
	m go a a		Marine	01		71	10 So	ller	s Po	int	Road,	Dunda	ilk,M	id.	
	`hysician		3a. Part I. Enter the disease, or failure. List only one cause	complications that on each line.	caused the death. I	Do not enter th	e mode of o	lying, s	uch as ca	rdiac or r	espiratory a	rest, shock,	or heart		Approximate Interval Between Onset and
	Medical Examiner		Immediate Cause (Final disease	a. Cardiom	egaly and c	concentri	c left	vent	tricul	ar hy	pertrop	hy			Death
	LXaiiiiici		or condition resulting in death)	Due to (or as	a consequence of):	:						-			
		٠	Sequentially list conditions,	b										_	
		ine	if any, leading to immediate cause. Enter Underlying Cause		a consequence of):	:									
		Examiner	(Disease or injury that initiated events resulting in death) Last	С	a consequence of):	:								-	
	d ansit		events resulting in death) Last	d.											
	8760, ificate be executed g physician and s the burial - transit	n/Medical	X UNPENDED	7	27 norME o	200 6/2/					•				
	se be	eq	IF FEMALE:		27, perME, g8		08 11					23 d E	Date of del	liveor	
	ന ≔ ≅ ഗ	2	23b. Was decedent pregnant in t		birth		al death	3	Ectopic	pregnano	CV		onth	Da	y Year
	Sox 687 leath certific e attending p	<u>i</u>	past 12 months?		nant at time of dea	th	ner (Specif)				_				
	Box 68 e death certi the attendin ed for use a	Physicia	1 Yes 2 No 9 Un	known 9 Unkr	nown										
	at the		Part II. Other significant condi	tions contributing	to death but not res	sulting in the u	nderlying ca	ause giv	en in Par	t I.	23e. Did	tobacco use	e contribu	te to th	e cause of death?
	P.O es that the iigned by be detac	by									1Y	es 2 N	10 3	Probal	bly 4 🗸 Unknown
	Division of Vital Records, its or Attending Physician: The law requirers after death. "In Director: After this certificate has been siled in by the funeral director, page 2 should be	Completed									24a. Wa	san			psy findings available
	law r has b	힐			_							opsy formed?		or to cou oth?	mpletion of cause of
	tal Rection: The certificate ector, page	Ö									1 🗸 Yes	2 No	1 🗸	Yes	2 No
	tal Re- tian: The certificate	Be (25. Was case referred to medica examiner?				26		of Death (Check on	ily one)				
	iz hysic	리	1 ✓ Yes 2 No	Hospital: 1	1 223	ER/Outpatient		4	Other ₄	Nursing	Home 5	Residenc	e 6(Other:	
	J of Jing Ph		27. Manner of Death	28a. Date (Mon	e of Injury th, Day, Year)	28b. Time of Ir			at Work?		8d. Describe	e how injury	occurred		
	tendi eath.	읥	1 X Natural 5 Pen 2 Accident Inve	ding stigation				1Y6	es 2	No					
	Vision or Attene fler death Director: in by the	<u>;</u>	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number or R or Town, State)									or Rura	Route Number, City		
	Division ospital or Attenchours after death neral Director:	E E													
	Hosp 24 ho Fune tely f		29a Certifier	hysician: To the be	est of my knowledge	e, death occur	red at the ti	me, dat	e and plac	ce, and d	ue to the ca	use(s) and r	manner as	stated	l.
	Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendir completely filled in by the funeral director, page 2 should be detached for use a	Medical	one) 2 Medical Exa	miner: On the basis	of examination an	d/or investigat	ion, in my o	pinion,	death occ	curred at	the time, dat	e and place	, and due	to the	cause(s)
	F & F S	Be	29b. Signature and title of certifi	and manner er	stateu.		29c. l	icense	number			29d. Da	te signed	(Mont	h, Day, Year)
•			-1/1	111 11:	4/			D.C.N	ſ.E.	OCME		March	n 27, 20	800	
			30. Name and address of person	M. K.	774	220)									
			Theodore M. King, Jr.	-	ant Medical E	•	111 Pen	n Stre	et. Bal	timore	MD 212	01			
			31. Date filed (Month, Day, Year)		Registrar's Signatur							-			
	St Regist	ate trar	ΔPR (1 1		2.42 - A	Angel	60								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 3:05 P M 2008 31 LORNE RANDOLF GUILD March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cockeysville

If Under 1 Year | If Under 24 Hrs.

Months Days Hours | Min. Baltimore County BROADMEAD Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs, last birthday) 5. Social Security Number **Funeral** 1**∑**M 2□F Director 212-05-3097 Texas March 7. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28e-f show 7 is marked other than "natural", or items 23a or 28e-f sho traumatic event, the Mudical Exerciting must be multipled at 1 ☐ Yes 2 No Directo Cockeysville Maryland Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages I and 2 should be filed within 72 hours after deeth v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Nudfeel Exempter 2008. 21030 13801 York Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ₩idowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Telecommunications Engineer 4 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Harry Fowler Anna Seebe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ms. Pricilla Guild (Daughter) 100 Virginia Avenue, Chaprl Hill, North Carolina 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State
4 Donation 5 Other (Specify) Green Mount Crematory 4/2/2008 Baltimore, Maryland 21. Signal de o Funeral S Avida Dio See MITCHELL-WIEDEFELD FUNERAL HOME, INC. Lawson 6500 York Road, Baltimore, Maryland 21212 Martin D. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause [Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 🗌 Yes 2 DNo 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Distursing Home 5 Residence 6 Other (Specify) 2 **D** No 1 🗌 Yes Certification: To this 27. Mann of Death in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After or Attanding 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerei L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 30. Name and address of person who completed cause YORK RD., COCKEY

DHMH 17 Rev 1/2001

State Registrar

ARROLL

32. Registrar's Signature

3801

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🛴 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Mar. 27 7:20 AM Patrick Hines 2008 Iron /Medical 4a. Facility Name (If not institution, give street and number) 6503 Hillop Ave. 4c. County of Dea or Location of Death Examiner Hilltop Baltimore If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, If Under 1 Year 9. Birthplace (State or Foreign **Funeral** Marylan 214-47-0347 1 M 2 □ F Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at 1 Dres 2 No Maryland Director 10f. Zip Code 10g. Citizen of What Cour by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 14. Race - American Indian. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Studen permit. Pages 1 and 2 should be filed or Department of Health and Mental Hygis Important: if item 27 Is marked other Mother's Name (First, Middle, Maiden Surname, Be injury or other traumatic ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or oth 1 Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funer Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Respiratory disease or condition resulting in death) /Medical Due to (or as consequence of): Examiner Scoliosis Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner encephalomalacia burial-transit Meningitic physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical led by the attending detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 1 🗌 Yes 3 Probably 4 □Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform this certificate 2 No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 1 🔲 Inpatient 5 Residence 6 □Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Peath 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State

Registrar DHMH 17 Rev 1/2001 Ma

3 Registrar's Signature

MD Pediatrics 105 Peninst Baltimere MD 21201

unia Klane il 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

jakeane

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene ≥ 0.03 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 4:40 PM THIC /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HAGENS WASHINGTON! TOWN 2000 If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Sex 7. Age (In yrs. last birthday) If Under 1 Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 □ F Usual Residence of Decedent 01, Director 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylar Department of Health and Mental Hygiene Important: If tiem 27 is marked other than "nature!; or Items 23a or 28a-f show any injury or other traumatic avent, the Modical Examiner Laust by notified any singery or other traumatic avent, the Modical Examiner Laust by notified any Singer. 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 0 Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Yo 11, Marital Status 1 Never Married 2 Married 1□Yes 2XNo Maryland 21215-0036 as Giva Specify: 3 Widowed 4 Divorced ear or Dates 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) onstruct 12an 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Comman Bacto. Johnson -9 Knew Ave Katherine 560 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State -27-08 3 rematory 4 ☐ Donation >5 ☐ Other (Specify) metro 22. Name and Address of acility 270 21. Signature of Juneral Service License reamil march 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or respiratory. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner 257 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): SRD burial-trar Due to (or as a consequence of): physician Physician/Medical as the IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, should be 2 DNO 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed 2/2 No Division of Vital 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) CENTERAN Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) NPILLELIN 2 ER/Outpatient 2 1 Inpatient 3□ DOA ihis 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Mannes of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deatl filled in by the 3 🗀 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 0 To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. License number who completed cause of death (Item 23a) (Type, Print) 30. Name and address of KOXBURY

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

2008

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Physician ·a /Medical City, Town, or Location of Death Examiner hicum touse If Under 24 Hrs. f Under 1 last birthday) **Funeral** Months Days Hours Min. 1 ☐ M 2 🕶 F Director Usual Residence of Decedent Baltimore 10d. Inside City Limits filed within 72 hours after death with the Maryland Hygiene. 10a. State 10h. County 28a-f show 1 es 2 No ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at Director 10g. Citizen of What Country? 10f, Zip Code 10e Street and Number 2122 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1□Yes 21 No Baltimore, Maryland 21215-0036 Specify. Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumath. College (1-4or 5+) Elementary/Secondary (0-12) iearS Mother's Name (First, Middle, Maiden Surname, Father's Name (First, Middle Be ssie Rural Route Num<u>ber,</u> City or Town, State, Zip Code) Glen Burn: Place of Disposition (Name of 3 ☐Removal from State Baltimore, and oudon 4 □ Donation 5 □ Other (Specify) uneral Services 21. Signat re o Funera Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) mos DU **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner be executed burial-transit Due to (or as a consequence of): Box 68760, cate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 9 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 2**/2**No 1∏ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 2 No 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 1 X Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined filled in by 4 ☐ Homicide Printing Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number d cause of death (Item 23a) (Type, Print) 0 ello 1 32. Registrar's Signature 31. Date filed (Month State

DHMH 17 Rev 1/2001

Registrar

3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home, farm, street, f building, etc. (Specify)	actory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) Certifying Phys 2 Medical Examir	Ician: To the best of my knowledge, death occurer: On the basis of examination and/or investigand manner stated.	curred at the time, date and place gation, in my opinion, death occ	a, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)
29b. Signature and title of certifier		29c. License number	29d. Date signed (Month, Day, Year)
Myez		030989	March 28 2008
30. Name and address of person who col	mpleted cause of death (Item 23a) (Type, Print		
Mula M Carper	Her MD 711 Mc	aiden Choic	e in Cotonsville MD
APR 0 1 200	32 Registrar's Signature	W	
	4 Homicide determined 29a. Certifier (Check only one) 29b. Signature and title of certifier	4 Homicide determined building, etc. (Specify) 29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29b. Signature and did of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sta Registr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Woodraw Horseman 28 : OS A M 2008 Migrich /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Morning side House Parkulle 7411 Baltimone If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2□ F Months Days Hours 220-01-0420 Director 89 2/17/1919 Maryland Usual Residence of Decedent 10a State 10c. City, Town or Location 10h County 10d. Inside City Limits show ral", or Items 23a or 28a-f shov Examiner must be notifled at 1 ☐ Yes 2 No Director MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a 2304 Edmondson Avenue 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 X Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No White Specify. 2 Specify 3 Widowed 4 Divorced Year or Dates: Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 8 0 Supervisor Mfq Important: If item 27 Is marked other any Injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fi Be Winfield Horseman Lena Willev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s Health ar Irene H. Schmidt / Sister 4411 Woodlea Avenue, Baltimore, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 20c. Location - City or Town, State ō 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 4/1/2008 Baltimore, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signatury of Funeral Service Licenses 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Vementa 42203 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed Due to (or as a consequence of): Box 68760, as the burial physician Physician/Medical nse (IF FEMALE If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Year 5 ☐ Other (specify) P.0. ☐Yes 2☐No the detached 9 ☐ Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ILTN Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Prostate Cuncu 24a. Was an has autopsy performed? Anamicthis certificate 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 DOther (Specify) 1955 34 36 Live 1 Yes 2 No 1 Inpatient P 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending 5 ☐ Pending investigation (Month, Day Year) Injury 1 Natural 1 ☐ Yes 2 ☐ No death 2 ☐ Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Medical (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

1304

N Charles SA

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701

10005Z

Year) 1 2008 31295

3/29/08

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

BUHN

N 5 Rujapar 7 NO

APR 0 1 2008

31. Date filed (Month, Day, Year)

00057465

23 Mainst, Suite 200, Reighnhown, MD 21136.

123108

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Vear **Physician** Harri 200 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Mary/and Year) 7 Date of Birth (Month, Day, If Under 24 Hrs. Hours Min. Age (In yrs. last birthday If Under Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 ☐ F Director 06 MD 50 214-68-4218 Usual Residence of Decedent death with the Maryland 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 TINo Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21217 U.S.A. 2502 Eutaw Place #106 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once. Black, White, etc. 1 Tes P No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: þ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Care First Claims Department 12th grade 3yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Doris Webster John Talbert ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21217 2502 Eutaw Place Apt 106, Baltimore, Shaeka Aleong-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition X☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/31/08 Pikesville, Md Druid Ridge 21. Sig of Funeral Service Licenstee March F/H West 21215 Μđ Baltimore, 4300 Wabash Ave, 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart billure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician cast /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner pue to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death the 9 Unknown 9 🗀 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 1□ Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital: 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 [] Homicide 24 hours a 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

30. Name and address of person (No completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 03 30 2008 Ann Harrid 10:47a ^M Mary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Sinai Hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
11 29 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1 ☐ M 2 🖫 F Director 249-62-0943 72 35 SC Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show items 23a or 28a-f shov iner must be notified at Yes 2□No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5141 Pembridge Ave 21215 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any Injury or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, GiveX Year or Dates: 3altimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify: ò Black 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Harlson and Elementary/Secondary (0-12) College (1-4or 5+) llth_grade Certified Nurse Assistant Convalescent Ctr. na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Gadsden Pearl Murray 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 5141 Pembridge Ave, Baltimore, Md ace of Disposition (Name of Date 20c, Location - City or Benjamin Keels-son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore National 4/4/08 Baltimore, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 21215 4300 Wabash Ave, Baltimore, Md 23a. Part . Enter the disease, or complications that ca, sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sh. c.k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme is te Cause (Final dise : e or condition esuring in death) **Physician** Deabelts /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as consequence of): Pusable and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 mo Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 5 ☐ Pending investigation 1 Natural Iniury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MI D 31464 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. ENTAW ST Ponte 305, BALTIMURE 1 mt 2 fot \$21 SHOAIB 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Same. Registrar

DHMH 17 Rev 1/2001

08-02504	
Mary Healy	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2	0	0	8	Well Street	0	3	9	2

		Registrar Certificate	rteg. No.					
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year						
		Facility Name (if not institution, give street and number) 815 Wellington Road	4b. City, Town, or Location of Death Baltimore 4c. County of Death Baltimore County	4c. County of Death				
Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or	-				
Director	ł	213_30_877/1	Hontho Davis House Min					
	1		s. Months Days Hours Mill September 4,1930 Country Marylan	1 <u>a</u>				
any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	ition 10d. Inside City Lin	mits				
≜ , 1	ē	Maryland Baltimore Baltimore	1Yes 2 XX	No				
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f sho natic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 815 Wellington Road	10f. Zip Code 10g. Citizen of What Country? USA					
th with ems 23:	Funeral	1 Never Married 2 Married Armed Forces?	as Decedent of Hispanic Origin? (Specify Yes or No- Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.					
fter dea l", or it		3XX Widowed 4 Divorced of Pare:	Yes 2XX No specify: Specify: White					
ours a atura	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Deced	nt's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry					
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	nost of working life. DO NOT use retired)					
03(rithin ene.	E	12	Homemaker Own Home					
21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medics		17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle, Maiden Surname)					
2121 wild be fi Mental marked c event,	a	George L Kilchenstein	Elizabeth Melka					
D 2: should and M 77 is m:	٤		ng Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	11/2				
Mag 2 Mag 2		3	Rodgers Court Baltimore, Maryland 21212 sition (Name of cemetery, Date 120c. Location - City or Town, State					
Ore, es la of He If ite		1 XX Burial 2 Cremation 3 Removal from State crematory or	other place)					
imore, MD 2121 Pages I and 2 should be fi ment of Health and Mental tant: If item 27 is marked or other traumatic event,		Zi z stration o justice appoint	Redeemer Cem April 2,2008 Baltimore, Maryla	nd				
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		21 rignature of Funeral Survice Licensee 22	Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc					
		Numes Sygnen remarks	6500 York Road Baltimore, Maryland 2121					
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	Between Onset					
xaminer	1	Immediate Cause (Final disease a. Atherosclerotic Cardiovascular D	sease Death					
		or condition resulting in death) Due to (or as a consequence of):						
	ᡖ	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):						
	듩	cause. Enter Unicerying Cause (Disease or injury that initiated						
± 1/4.	Examiner	events resulting in death) Last Due to (or as a consequence of):						
8760, tificate be executed ng physician and as the burial - transit	E E	d						
1 2 2 6 E	ğ	UNPENDED						
8760, rificate b ing physic	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2	etal death 3 Ectopic pregnancy 23d. Date of delivery Month Day Year					
K 68	ia.	past 12 months?	Other (Specify)					
Box e death c the atten ed for us	ysi	1 Yes 2 V No 9 Unknown g Unknown						
P.O. Box 61 s that the death cert med by the attendir		Part II. Other significant conditions contributing to death but not resulting in the						
, P.O. res that the signed by be detacl	d by		1 Yes 2 No 3 Probably 4 V Unknow	WII :				
ords, law requir has been s	Completed		24a. Was an autopsy findings avail prior to completion of cause					
e law	E C		performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No					
Vital Rec ysician: The l		25. Was case referred to medical	26.Place of Death (Check only one)					
Vita hysician this cer	o Be	examiner? Hospital:	Othor					
of Vital Records, ng Physician: The law requir Witer this certificate has been some and inector, page 2 should	-	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Death	territoria de la constanti de					
nding ath.	흲	Natural 5 Pending	1 Yes 2 No					
Division tal or Attendi rs after death. af Director: /	ica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, st	eet, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number,	City				
Division of Vitalian or Attending Phours after death. Teral Director: After titled in by the funeral	Certification:	3 Suicide 6 Could not be determined (Specify)	or Town, State)					
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
								2
	Culu-Cu - Stee Ms							
10		30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner	111 Penn Street, Baltimore, MD 21201					
St Regist	ate trar	31. Date filed (Manth Day Year) 2008 33 Registrar's Signature	de					
DHMH 17 Rev 1/2		OCME ORIGIN						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year **Physician** THERESA 0506 AM MARCH 28 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE JOHNS HOPKINS BAYVIEW MEDICAL CENTER N/AIf Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🙀 F 83 Yrs. Director 219-18-0646 01-05-1925 Maryland Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Dundalk Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1953 Inverton Road 21222 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 72 Elementary/Secondary (0-12) College (1-4or 5+) Child Day Care Provider Child Care 12 should be filed what and Mental Hygies is marked other the injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked o any injury or other traumatic. Frank Vivirito Mary Mascari 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carl R. Hickey (Son) 1300 Corbett Road Monkton MD. 21111 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) | Cedar Hill Cemetery 1 ☑Burial 2 ☐ Cremation 3 Removal from State 03-31-2008 Brooklyn Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of FacilityDuda-Ruck Funeral Home of Dundalk Inc. 7922 Wise Avenue Dundalk MD. 21222 23a. P.m.1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician RESPIRATORY ACIDOSIS DAYS /Medical Due to (or as a consequence of): Examiner HEMORRHAGE DAYS INTRACRANIA Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit certificate be executed and Due to (or as a consequence of): attending physician Physician/Medical use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy P in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☑ Unknown Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> 1 Yes 2 No 3 Probably 4 Onknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No autopsy performed? certificate 1□ Yes 2⊞No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 100 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 TYes ည this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident in by the 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760, after death

Baltimore,

within 24 hours aft

To the Funeral Di

completely filled in To the Hospital

Medical State Registrar

SOFIA

29a, Certifier

RES - 000

29d. Date signed (Month, Day, Year)

MARCH 28,2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LYFORD-PIKE 4940 EASTERN AVENUE BALTIMORE MD 21224 32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

31. Date filed (Month, Day, Year) APR 01

29b. Signature and title of certifier

2008

and manner stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Amend Ite	State of Ma em 23a per	aryland dr.,	/ Depa g8/8	ortment of 1 04/01/08/	lealth ar lhb Death	nd Menta	al Hygie Reg.	ne _{No.} 2 0 (38	10394	
験	Physici		1. Decedent's Name (First, Middle, La.	150V						ite of Death	pay 20	rear	3. Time of Death	
5	/Medio		4a. Facility Name (If not institution, give Mary and 54) 5. Social Security Number 6. S	e street and number)	05017 e (lh yrs. la	all st birthday)	Baltin If Under 1 Year	r Location of I	CXX	tte of Birth	4c. County of		ace (State or Foreign	
	Funeral Director			□M 2 ⊠ F	56	Yrs.	Months Days		Min. (M	onth, Day, Ye	ear)	Count		
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	ŗ	10a. State 10b. County			Town or Lo						10	d. Inside City Limits 1XXYes 2 □ No		
	Director	MARYLAND N/A 10e. Street and Number		E	BALTIM	ORE 10f. Zip Code			10g.	Citizen of Wh	at Count			
	tth with 23a ol ust be										U.S.A.			
36 rs after dea r', or items xaminer m	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🕺 If Yes, Give Year or Dates:		i	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	lispanic Origir an, Mexican, F Specify:	n? (Specify Yo Puerto Rican,	es or No- etc.)	14. Race - Black, Specify:	America White, e	tc.		
215-0036 tthin 72 hours af te. an "natural", or Medical Exami		Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)						of working	16b. Kind of Business/Industry				
12 p	be filed wit ital Hygiene id other the event, the	To Be Con	12th grade 17. Father's Name (First, Middle, Last)			HOUS	EWIFE	18. Mother's	s Name (First		N/A den Surname))		
lan	S = 0		JOHN CUNNINGHAM						IE MAE		·			
ore, Maryland ss 1 and 2 should be file of Health and Mental Hy iftem 27 is marked oth	-	19a. Informant's Name/Relationship (Type. Print)		19b. Mailir	ng Address (Street	and Number	or Rural Rout	e Number, C	ity or Town, Si	tate, Zip	Code)		
	1 and Health em 27 ther t	l i	Antoineya Harriso 20a. Method of Disposition	n/Daughter	20b. Pla	ce of Dispo	Richards	i	., Balt		, Maryl			
Ē			1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif				natorý or other plac CEMETERY	i	3-28-08	R T.AI	NSDOWNE	7. MZ	ARYLAND	
Baltimore,	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Light	isee		22 W	Name and Addre ILLIAM C 206 W NOI	ss of Facility BROWN	COMMUI					
	5518		Condin Domination Annual Onset and Dea										Approximate Interval Between Onset and Death	
1	/Medical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	a conseque	ence of):	_			., 11.1.		-		
	Examiner	<u>-</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):							ure				
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events Alcoholic Li						Liver I	ver Disease				
8/60,	ficate be executed physician and s the burial-transit	dical Ex	resulting in death) Last	Due to (or as a consequence of):										
٥	certifica ding ph se as th	/Med	IF FEMALE:	23c. If yes, outcome	nf pregnan	CV					and Date	at dell'		
IN OF VITAI HECORGS, P.O. BOX 6 fing Physician: The law requires that the death certificate has been signed by the attending uneral director, page 2 should be detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal	death 3□	Ectopic pregnancy Other <i>(specify)</i>	/			23d. Date Mont		y Day Year		
	Completed by Ph	Part II. Other significant conditions of Hepatic Ence				, ,		23	3e. Did tobac 1		ute to the	e cause of death?		
		Peritonitis	5						4a. Was an autopsy performed	d? pri	ere autop or to com ath?]Yes	sy findings available apletion of cause of		
	Be	25. Was case referred to medical examiner?	Hospital:			Oth	or.	f Death (Che						
	7. To	1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Home 5 Res								sidence 6 Other (Specify) how injury occurred				
IVISION	Attending r death ector: Atter by the 'uner	atio	2 Accident investigation M 1 Yes 2 No											
Hosp 24 hou Funer		Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Lo <i>Ci</i>	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
		Medical C	29a. Certifier (Chack only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										ated. the cause(s)	
)	To the within 2 To the complet	Me	29b. Signature and title of certifier	Beinn	01	MC	29c. Licens	e number 1554	′	29d.	Date signed	(Month, E	Day, Year)	
	(2)		30. Name and address of person who	and m	1.	1/7	Mary Mary	Iland	Gilne	ral	Hosp.	tal)	
	Sta Registr		APR 0 1 2008	32. Registr	ar's Signatu	perte	*				<i>y</i>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1:00 AM Kevin Jackson march Z8 2008 4c. County of Dea 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Baltimore Hospital Hopkins Johns 8. Date of Birth Month, Day, Year Aug. 30, 19 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Social Security Number 1 M 2 □ F Months Days Marland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Des 2 No Maryland 10g. Citizen of What Country? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: 3 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry December 5 based Occupanting most of working life. DO NOT use retired) Retail Fila Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last

19b. Mailing Address (Street and Number or Rural Route Number

Physician /Medical

Physician

/Medical

Examiner

10a. State

Director

Funeral

9

Be Completed

ို

Funeral

Director

than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any Injury or other traumatic event, the Medical Examiner must

Maryland 21215-0036

Baltimore,

Examiner

and burial-tran

physician

as the attending use

for

, page 2 should

director

þ

Completed

Be

Certification: To

27. Manner of L

29a. Certifier

1 Natural

2 Accident

3 ☐ Suicide

4 Homicide

the detached

signed by

certificate has

this

After

within 24 hours after death To the Funeral Director: filled in by the

Physician:

or Attending

Hospital

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

disease or condition resulting in death) Examiner Physician/Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

in the past 12 months? 1 ☐ Yes 2 ☐ No

Kobert

20a. Method of Disposition 1 ☐ Burial 2 ☐ remation

4 ☐ Donation

Immediate Cause (Final disease or condition

23c. If yes, outcome pf pregnancy
1 ☐Live birth 2 ☐ Fetal dea
4☐Pregnant at time of death
9□Unknown

3 Ectopic pregnancy 5 ☐ Other (specify)

20b. Place of Disposition (Name of

m (

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line.

OSIS

Due to (or as a consequence of):

Due to (or as a consequence of)

Due to (or as a consequence of):

Preumonia

23d. Date of delivery Day Month

City or Town, State, Zip Code)

Year

roximate erval Between set and Death

12 hours

3 months

3 Girliowi	1						
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?						
	1 ☐ Yes 2	No 3 Probably 4 Unknown					
	24a. Was an autopsy performed? 1 Yes 2 3 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No					

25. Was case referred to medical examiner? Hospital: 1 Yes

5 Pending investigation 6 ☐ Could not be

Jacks

5 ☐ Other (Specify)

3 Removal from State

19a. Informant's Name/Relationship (Type. Print)

21. Signature of Fureral Service Licensee

hoatient Date of Injury (Month, Day Year) 28a

and manner stated.

2 ER/Outpatient 3□ DOA 28b. Time of Injury

Injury at Work? 1 Yes 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one) 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Army DeZern T 31. Date filed (Month, Day, Year)

Medical Doctor 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Res - 000

26. Place of Death (Check only of

State Registrar APR 0

400 North Wolfe Street Bainmore Haryland 21287 The Johns Hopkins Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician WILLIAM 806 PM JACKSON March 26,2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE BALTIMORE GOOD SAMARITAN HOSPITAL CITY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Birthplace (State or Foreign
Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 215-62-855 1 4 2 F Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at Baltimore 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code Emge 21234 U.S. Funeral 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status s 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 is marked other than "natural", or iten other traumatic event, the Medical Examiner 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black Specify: Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Improvement 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ethel Lee ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 38th Street Baltimore, MD 208 Name of Date 20c. Location - City or Town, State Jackson OFi permit. Pages 1 a
Department of Hea.
Important: If Item 2
any injury or 7.7 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State awn 4.3.2008 Baltimore MD
22. Name and Address of Facility Vaughn C. Greene Funeral Services 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 4905 York And Baltimore, MD 21212 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE MYOCARDIAL INFARCTION /Medical Due to (or as a consequence of) Examiner CAPDIO VASKULAR DISTASE ATHEROSCLEROTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical asn 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a Was an autopsy 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 EB Outpatient 3 DOA 2**2**No 1 ☐ Yes 1 Inpatient Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated. 29d. Pate signed (Month, Day, Year)
North 26, 2008 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of seath (Item 23a) (Type, Print) OCH PAVEN BLUD BALTIMORE, MD ZIZZ JUSEPH KER ITH Registrar's Signature 31. Date filed (Month, Day, Year) State APR 0 1 2008

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. and items 1 per doc 5.19a per fin 882 8-14-08 vt. State of Maryland 7 Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Matilda Florence Jackson Month Day **Physician** dollso 16, March 2008 9:30A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1314 Farmingdale Ave. Chapel Oaks Prince Georges 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** 1 ☐ M 2 ☐ XF Months Days Yrs. -10-2/Washington DC 86 Director Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County rthen "naturel", or iteme 23a or 28a-f ehow tre Medical Examiner must be notified at 1X Yes 2 □ No MD Chapel Oaks Prince Georges Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 20743 USA 1314 Farmingdale Ave Funeral withIn 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black δ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Peges 1 and 2 should be filed withIn Depertment of Heelth and Mental Hygiene. Importent: If item 27 ie marked other then ' Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Naval Annex 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William H. Taylor Beatrice Fulton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20743 4803 Addison Rd. Apt, 103 Capitol Heights MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ØBurial 2 ☐ Cremation 3 ☐ Removal from State 3-24-3008 Washington, DC Olivet 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility eny ir UNASUNS S635 ECNS 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac poick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a con equence of): Examiner Socuertially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physicien and The law requires that the death certificate be executed Due to (or as a consequence Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached for o 9□ Unknown 9 Unknown <u>م</u> been signed t should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ۾ 1 ☐ Yes 2 12 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No of Vital : After this certifice funeral director, I 25. Was case referred to medical examiner? 26. Place of Death [Check only one] Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? To the Hospital or Attending PI within 24 hours efter death.
To the Funerel Director: After the completely filled in by the funeral 27. Manner of Death 28d. Describe how injury occurred Certification; Division 1 Natural 5 Pending investigation 1 Tes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a Certifier 29b. Signature and Mile of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO013231 9470 Ann 32. Registrar's Signature homas INO 31. Date filed (Month, Day, Year) State APR 0 1 2008

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month /Medical 4b City, Town, or Location of Death Facility Name (If not institution, give street and number, Examiner County of Death BON SECOURS 405 BALTIMORE 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day Year) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🐪 F Months Days Hours Min 169-20-7 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show idical Examiner must be notified at 10d. Inside City Limits Director MD1 Yes 2 No timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Silmore Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 North of the Period Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: er than "natura", the Medical E Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
The DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ": If item 27 is marked other than or other traumatic event, the Me Elementa Secondary (0-12) College (1-4or 5+) 8.th Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental ames Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rujal Route Number, City or Town, State, Zip Code) Niece Monda 212 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1 Department of H Important; If ite any injury or otl Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kaltimore 21. Signature of Funeral Service Licensee 23a. Part1. Enter the diveasion shock, or heart 1 lure. ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to or as a consequence of): /Medical **Examiner** Sequentially list conditions, if any leading of the clat-cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a nonneguence of To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1☐Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 9□Unknown Month Day Vear 5 ☐ Other (specify) 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ₽ onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan autopsy performed? /es 2 1∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ SOA After this 5 ☐ Residence 6 ☐ Other (Specify) 27. Manne of Death 1 Natural 28a. Date of Injury (Month, Day 28h Time of 28d. Describe how injury occurred Year) 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Division or Vital Records, P.O. Box 68760, within 24 hours after To the Funeral Dire

> State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month: Day Year) 2008

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DA Joth MARCH 29,2008

Please Type or Print in Black Indelible Ink. Ensure All Copies State of Maryland / Department of Health and Mental Hyg

)	0	\cap	0	- 1
	U	0	0	

s Are Legible.	000	0	1 6	50	0.0
raiene	71111	7		1.5	77

		Registrar	cate of Death	Reg. I	No.	
Physici Lical Exam		Decedent's Name (First, Middle, Last)		Date of Death Month Date	ay Year	3. Time of Death
Cai Exam	Hiei	Brenda S. Jamison 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat	March 25, 20	4c. County of Death	1024 hrs
•		1216 Homewood Avenue	Baltimore	1	N/A	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last b	oirthday) If Under 1 Year If Under 24Hr	8. Date of Birth (N	MM/DD/YYYY) 9. Birti	
Director		217-70-1733 1-M 2-XF 53	Yrs. Months Days Hours Mir	11/30/	1954 Foreign	untry) Md.
		Usual Residence of Decedent		111/00/	2001	
w any		10a. State 10b. County 10c. City, Tow	n or Location			10d. Inside City Limits
Maryland 28a-f show d at once,	tor	Md. N/A Balt	imore			1 XYes 2 No
ith the Maryland 23a or 28a-f sho notified at once.	irec		10f. Zip Code	10g.	Citizen of What Coun	itry?
with the s 23a e notil	Funeral Director	1216 Homewood Avenue 11. Marital Status 12. Was Decedent Ever in U.S.	21201 13. Was Decedent of Hispanic Origin? (S	nedify Yes or No-	USA 14. Race - Americ	can Indian Black
death wi	nue	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puerto		White, etc.	San Indian, Diack,
after call", on	by F	3 Widowed 4 Divorced of Yes, Give Year or Dates:	1 Yes 2 X No specify:		Specify: B1:	ack
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner			 Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret 		b. Kind of Business/Ir	ndustry
36 in 72 han " tical J	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)				
-00; d with ygiene ther t		12 17. Father's Name (First, Middle, Last)	Supervisor 18. Mother's Name	e (First, Middle, Maid	BWI Airpo	ort
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	Be C	Ernest Taylor		de Mattl		
21 hould and Men is man			9b. Mailing Address (Street and Number or			Zip Code)
', MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland eath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once		Theodore Jamison	1216 Homewood Ave			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical			e of Disposition (Name of cemetery, atory or other place)	Date 20	c. Location - City or	Fown, State
ti Pag tment rtant:		4 Denation 5. Other Specify: West	ern Cemetery 4/2	/2008 I	<u>Baltimore</u>	e, Md.
Balti permit. Departm		21. nature of Funeral Service Licens	22. Name and Address of Facility Estep Brothers	Funeral	l Service	e, PA
Physician		23a. Part . Enter the disease, or complication, that caused incideath. Do r	not enter the mode of dying, such as cardiac of	CE, Balt: or respiratory arrest,	LMOTE, Mo	d. 21217 Approximate Interval
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Internal Hemorrhage due to	o metastatic luno carcinoma			Between Onset and Death
varniner		or condition resulting in death) Due to (or as a consequence of):				
	<u></u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	ä	cause. Enter Underlying Cause (Disease or injury that initiated				
Bit ed M	Examiner	events resulting in death) Last Due to (or as a consequence of):				
760, scate be executed physician and the burial - transit	ical	unpended amended				
7 60, ficate be ex g physician the burial	//Medical	IF FEMALE: 23c. If yes, outcome of pregnancy	v		23d. Date of delivery	
687 ertifica ding p e as th	an/I	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 Ectopic pregna		Month Da	ay Year
Box 68 e death certif the attending	Physiciar	1 Yes 2 No 9 Unknown	5 Other (Specify)			
ords, P.O. Box 68 w requires that the death certif s been signed by the attending should be detached for use as		Part II. Other significant conditions contributing to death but not resulting	ng in the underlying cause given in Part I.	23e. Did tobac	co use contribute to the	ne cause of death?
, P.O. res that if signed by be detacl	d by			1 Yes 2	No 3 Proba	ably 4 🗸 Unknown
rds requi	Completed			24a. Was an autopsy		opsy findings available ompletion of cause of
ecol he law ate has	d w			performed	? death?	
Vital Rec ysician: The l his certificate !	Be	25. Was case referred to medical	26.Place of Death (Check		1 163	2 140
Vita Physici this c	To E	TIVITES 2 INC	Outpatient 3 DOA Other Nursin	g Home 5 Res	idence 6 🗸 Other:	Scene
Division of Vital Records, tal or Attending Physician: The law requirrs after death. al Director: After this certificate has been siled in by the funeral director, page 2 should be		1 Month, Day, Year)	. Time of Injury 28c. Injury at Work?	28d. Describe how	njury occurred	
ivisior or Attend after death Director:	cati	2 Accident Investigation	1 Yes 2 No			
Divirus after rs after led in	Certification:	3 Suidde 6 Could not be determined (Specify)	farm, street, factory, office building, etc.	or Town, State)		al Route Number, City
Hospi 24 hou Funer tely fil		29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, de	eath occurred at the time, date and place, and	due to the cause(s)	and manner as states	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Medical	one) 2 Medical Examiner: on the basis of examination and/or	investigation, in my opinion, death occurred a	t the time, date and	place, and due to the	cause(s)
	ž	29b. Signature and title of certifier	29c. License number	. 290	d. Date signed (Mont	h, Day, Year)
y			O.C.M.E.	M	arch 27, 2008	
OCME		30. Name an la dress of erson who completed cause of death (Item 23a)	r 444 Dam Ci - 7			
	ate	Mary Ripple MD. Deputy Chief Medical Examine	111 Penn Street, Baltimore, M	21201 ט		
Regis	rar	31. Date filed (Month, Bay Year) 1 2008 32. Rustrar's Signature	Grade			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Registrar	State of M	laryland / Depa <i>Cer</i>	ertment of F ctificate of a				8 10400
-	sicia edica		,	arah Johns			2. Date of Dea Month	th Day Yea Mar 26, 2008	3. Time of Death 0630 M
Exa	mine	Gilchri	ive street and number st Center for He		4b. City, Town, or	r Location of Death	wson	4c. County of D	eath Baltimore
Fune Direc	_	5. Social Security Number 6. 214-22-6374 Usual Residence of Decedent	Sex 7. A 1 □ M 2 □ F	ge (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Nov 9	Year) 9. E	Birthplace (State or Foreign Country) Maryland
Maryland -f show	18 24	10a. State 10b. County	N/A	10c. City, Town or Loc		Baltimore			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
with the 3a or 28a	N. C.W. DOLL	Maryland 10e. Street and Number 1630 Balmor Court 11. Marital Status 1 □ Never Married 2 □ Married			10f. Zip Code	21217	1	0g. Citizen of What	Country?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or frems 23a or 28a-f show any Initiary or other than "natural", or frems 23a or 28a-f show		11. Marital Status 1 Never Married 2 Married	12. Was Decedent Armed Forces' 1 Yes 2	1 00		lispanic Origin? (Span, Mexican, Puerto	pecify Yes or No- pecify Yes or No- pecify Yes or No-		merican Indian,
21215-0036 d within 72 hours aft giene.		3 Widowed 4 Divorced 15. Decedent's E (Specify only highest gr	If Yes, Give Year or Dates: ducation rade completed)	16a. Deced	ent's Usual Occup	during most of work	sina	Specify: 16b. Kind of Busines	Black ss/Industry
aryland 2121 should be filed within and Mental Hygiene. marked other than "		Elementary/Secondary (0-12)	College (1-4or	lite D	O NOT use retired	memaker			vn Home
Maryland nd 2 should be file alth and Mental Hy 27 is marked oth	Halle of	Frede	rick Harris	1401 14 11		18. Mother's Nam	Le	ona Harris	
e, Ma 1 and 2 sl Health an em 27 is i		19a. Informant's Name/Relationship Marsha Smith Daught 20a. Method of Disposition		2:	328 Garrett A	Avenue Baltim	nore, Marylar		· · · · · · · · · · · · · · · · · · ·
rmit. Pages 1 ar ppartment of Hea portant: If item		1 ☐ Burial 2 ☐ © remation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of Co	fy)	Metr	atory or other place o Crematory,	, Inc.	03/27/08	20c. Location - City o	ille, Maryland
Depa Derm	ouce	21. Sign turn of Funeral A ry ce Lice	125	Yex	Name and Address Estep E 1300 E	Brothers Fund	eral Service, Baltimore, Mo	P. A. 121217	
Physici /Medic Examin	al	23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. MIII-SI	ne.	WM CAN		or respiratory arre	est,	Approximate Interval Between Onset and Death
oertificate be executed right physician and ise as the burial-transit	Eval leving	Sequentially list conditions, if any, leading to infiniteliate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):		8			
atter for u	ian/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other <i>(specify)</i>	,		23d. Date of o	lelivery Day Year
cords, P.O. w requires that the desired should be detached	ž	AMA A COMMAN AMPLIA		ut not resulting in the und	derlying cause give	en in Part I.	23e. Did tob		to the cause of death? Probably 4 🗆 Unknown
D & B CD	1 2						24a. Was ar autopsy perform 1 □ Yes 2	/ prior to ned? death?	autopsy findings available of completion of cause of
DIVISION OF VITAL HA To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	To Be	25. Was case referred to medical examiner?		ent 2 ☐ ER/Outpatient	3 □ DOA Othe	26. Place of Death	h <i>(Check only one</i> ime 5 ☐ Reside		pecify) #DSPICE
INISION (I or Attending I after death. Director: After din by the funer.	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b	e	y, Year) Injury		rat ? res 2 □ No	28d. Describe ho	w injury occurred	
DIVI pital or Al urs after o	Certifi		building, et	ury - At home, farm, stree c. (Specify)			City or Town,	State)	Rural Route Number,
the Hos thin 24 ho the Fune	Medical	one) Page Medical Example one	nysician: To the best miner: On the basis o and manner sta	of my knowledge, death of examination and/or invested.	estigation, in my op	pinion, death occur	red at the time, da	ite and place, and di	ue to the cause(s)
\(\frac{1}{2}\)	5				29c. License	120C		NARCH 24	1200
		30. Name and address of person who DANIEUE OCHETS 31. Date filed (Month, Day, Year)	completed cause of d	eath (Item 23a) (Type, Pr	HARLES	ST, SUITE	£ 209	BALTIMO	RE, MD 21204
	State strar	APR 0 1 200	8 Linegistr	S Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month 25, 2008 4c. County of Death 2:13P M FRANCES MATHILDA COWLES KAVANAGH March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Towson der 1 Year If Under 24 Hrs. MANOR CARE NURSING CENTER-RUXTON Baltimore County If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) Apr 5, 190 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2XF Hours 214-20-7227 Usual Residence of Decedent 102 Director Pennsylvania the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 ☐ Yes 2X No Directo Maryland | Baltimore County Parkville 10e. Street and Number 10g. Citizen of What Country? other than "natural", or Items 23a or vent, the Medical Examiner must be r 2613 Wendover Road 21234 USA Pages 1 end 2 should be filed within 72 hours after death nent of Haelth and Mental Hygiene. Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No WWI If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married WWII Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: White δ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Medical Registered Nurse 27 is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Albert E. Cowles Clara Belle Fleming 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I Rep.) 2613 Wendover Road, Baltimore, Maryland 21234
20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Mrs. Mary Patzschke (Pers. 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) ō = permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cemetery 3/31/2008 Baltimore, Maryland 21. Signatur Functal Service Livensee

Martin D. Lawson MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) o Cardial **Physician** /Medical Due to (of as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine sicien end The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): physicien s the burial Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. F been signed by the should be deteched 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? certificate hes t irector, page 2 s autopsy performed? 1 Yes 2 No 1 Yes 2 No Division of Vital After this certification of funeral director, or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Aursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 ☐ Yes 2 ☑No 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Watural 5 Pending eftar death. I Director: Aft d in by the fun 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours effar of To the Funeral Directorphietely filled in by 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number H0054424 3-26-08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7001 North Charles Street, Towson, Maryland 21204 Cyrus Asadi, D.O., /32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year) APR 0 1 2008

Coarles

Division or Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified

3

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifie

and manner stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** March 23, 2008 6:15 A M John James Kane, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Greater Baltimore Medical Center Towson If Under 1 Year If Under 24 Hrs. **Baltimore** . Age (In yrs. last birthday) Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1⊠M 2□F Director 75 201-24-6482 6,1932 Pennsylvania Sept. Usual Residence of Decedent 10b. County 10c. City. Town or Location 10a. State 10d. Inside City Limits 28a-f show ral", or Items 23a or 28a-f sh Examiner must be notified 1 ☐ Yes 2 🔀 No Director Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 1900 Grove Manor Drive Apt. 107 United States Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 [7] Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married "natural", or 1 ☐ Yes 2 ☑ No Specify þ Specify 3 ☐ Widowed 4 ☐ Divorced White Korean Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 9 Years Foreman Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret Murray James A. Kane 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 600 Loring Ave. Bel Air, MD 21014 (Son) Mr. John J. Kane, Jr. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or oti 1 DBurial 2 □ Cremation 3 □ Removal from State Garrison Forest V. A. Cem. 3/28/2008 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Licenses 7922 Wise Ave. Dundalk, Maryland 21222 ant 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Kishiratan Physician 101 resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal deal 4 ☐ Pregnant at time of death 2 Fetal death 3 □ Ectopic pregnancy in the past 12 pronths? 1 ☐ Yes 2 ☑ No Month Day 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Polmonary 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy certificate ha performed! Yes 2 No Dighton or Attending Physician: To Be 25. Was case referrexaminer? ed to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manyer of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number

within 24 hours after death

To the Funeral Director;

completely filled in by the f

State

Registrar

31. Date filed (Month, Day, Year)

APR 01

2008

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Neal M Fredly nder moderate of LEPOI N. Charles St. Site 5105 Battings Mayland 21205 32 Registrar's Signature

29d. Date signed (Month, Day, Year)

State

State Registrar 31. Date filed (Month, Day, Year)

APR 0

DHMH 17 Rev 1/2001

NIENTAM ST Shite 368, BALTIMORE MI)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

821

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day March 28, 2008 Menn /Medical 4:15 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Med Ctr Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 12/17/1951 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 D F 56 Director 217-58-0308 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show edical Examiner must be notified at Director 1 Yes 2 No Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 260 9th Street 21122 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specify: 3 Widowed 4 Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Pages 1 and 2 should be filed within 72 P nent of Health and Mental Hygiene. int: If Item 27 is marked other than "nat (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Contractor Swimming Pools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Glenn Ernest Lail, Sr. Dora Adeline Spencer other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 260 9th Street, Pasadena, Deborah Lail / Wife MD 21122 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any Injury or c 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 04/01/08 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility G.J.Gonce Funeral Home, 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Ent a the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiral ory arrest shock, on earl failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Couse (Final disease or condition resulting in death) **Physician** Mocard /Medical Due to (or S Examiner CO Sequentially list on dilions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-trar Due to (or as a consequence of): physician Physician/Medical the as IF FEMALE: yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ should be Be Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an funeral director, page 2 autopsy perforn 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 2 Accident 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mainer as stated.

Division or Vital Records, P.O. Box 68760√

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)



Car

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 200 3 2008 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Health 3 hehabilitation 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □M 2 □ F **Director** Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits must be notified at Baltimore 1 Ves 2 No Director 28a-f M_{l} 10e. Street and Number 10g. Citizen of What Country? 5 ō 21206 23a Completed by Funeral Items ? Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 Ho
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bace - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 ZHO Specify: 3☐Widowed 4☐Divorced Specify: Black "natural", 15. Decedent's Education (Specify only highest grade completed) other than "natu vent, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Se econdary (0-12) College (1-4or 5+) and Mental Hygiene. .Gundr 17. Father's Name (First, Middle, Last) Be 27 Is marked or traumatic even = lenor 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 Baltimore, MD 21206 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any Injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State Baltimore, MI) 12008 4 Donation 5 Other (Specify) Lorraino Varighn C. Greene Function Services 21. Signature of Funeral Service Licensee Um Baltimore 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence or) Examine The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical anding p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atter for u 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MUnknown should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed? res 2000 certificate 1□ Yes To the Hospital or Attending Physician: director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Certification: To this funeral Manner of Seath
Natural
Call Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Injury death. 1 ☐ Yes 2 □ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

© Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year)

March 27 (1) 29b. Signature, and title of cer 30. Name and address of derson who completed cause of death (Item 23a) (Type Print) 560 dre 40 Registrar's Signatur Tar 2008 State Registrar

DHMH 17 Rev 1/2001

Registrar

APR 0 1 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - Stete Registrar	State of Ma	arylan		•	nt of Hea te of De		Mental Hy	giene Reg. No.	UUD	10408
	Physici /Medic		Decedent's Name (First, Middle, La.	Robert	Wi	llia	ım L	itzau		2. Date of De Month March	Day 31	Year 2008	
	Examin Funeral Director		4a. Facility Name (If not institution, given 715 Maiden Choose Social Security Number 6. S 219-16-6418	oice Ln.,		-402 last birtho	C C			th B. Date of Bi	4c.	County of Dea	ath
	/land ow at		Usual Residence of Decedent 10a. State 10b. County				r Location			12211	,		10d. Inside City Limits
	Ba-f sh	Director		timore					nsvill	le			1 □ Yes 2X No
	3a or 2	Dire	10e. Street and Number 715 Maiden Cl	noice In	н	V-40		ip Code 2.1	.228		10g. Citi	izen of What C USA	•
36	ges 1 and 2 should be tited within 72 hours after death with the Maryland t of Health and Mental Hygiene. If item 27 is marked other than "natural", or Itema 23a or 28a-f show or other traumatic event, Ita Medical Examinar must be notified at	by Funeral	11. Marital Status 1 \(\overline{\chi} \) Never Married 2 \(\overline{\chi} \) Married 3 \(\overline{\chi} \) Widowed 4 \(\overline{\chi} \) Divorced	12. Was Decedent E Armed Forces? 1 X Yes 2 \(\sqrt{N}\) If Yes, Give Year or Dates:\(\sqrt{N}\)	ver in U.	S.	13. Was Dec If Yes, sp	edent of Hispa ecify Cuban, N		Specify Yes or No to Rican, etc.)	D-	14. Race - Am Black, Wh	erican Indian,
Maryland 21215-003	nin 72 hou in "nature Medical E	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation		16a. De		ual Occupation rork done durin use retired)		orking	16b. Ki	ind of Business	
272	filed with Hygiene other tha	Com	11 1. Father's Name (First, Middle, Last)	College (1940) 3	τ,		C1	erk	Mother's Na	me (First, Middle			curity Adm.
/lanc	2 should be tand Mental I is marked or aumatic eve	To Be	Harry	August	Li	tzau	l	10.		ellie	, maider	Re	ad
Mar	id 2 sho Ith and 27 is ma		19a. Informant's Name/Relationship (Virginia L. Rei		۵r			ss <i>(Street and</i> eland		Cat on		r Town, State, Lle, M	
ore,	pes 1 and of Health If item 27 or other tr		20a. Method of Disposition 1 ▼ Burial 2 □ Cremation 3 □					ame of other place)	Road	Date		ocation - City o	
altimore,	t. Pa ntmen rtent:		* 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen)				Cemeter	-			ltimor	e, MD Home, P.A.
ñ	Depa Impo any ir		Seon E.	Monds	1		301	Frede	rick	Road C	ator	nerai nsvill	e, MD 21228
	Physician /Medical Examiner	-a	23a. Part1. Enter the disease, or compands, or compands, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a. Due to (or as a	a consequ	y Cl uence of):	ond	L CA	en as cardia	OVAM	ula	ir A	Approximate Interval Between Onset and Death
28760,	ificate be executed g physician and as the burial-transit	edical Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	a consequ	uence of):							
O. Box	ath certif attending for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 🗌 Fetel	death	3 □Ectopic 5 □ Other (2	23d. Date of de Month	livery Day Year
rds, P.	w requires that the de been signed by the should be detached	þ	Part II. Other significant conditions of	ontributing to death bu	t not resu	ulting in th	e underlying	cause given in	Part I.				o the cause of death?
Vital Records,	(g LL	Completed								24a. Was auto perfo 1 Yes		prior to death?	utopsy findings available completion of cause of
	ysician: Th s certificate director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatier	nt 2 🗆 I	ER/Outpa	tient 3□ D	Othor		ath (Check only o		3 ∏Other (Spe	ecity)
Division of	Hospitat or Attending Physician: 24 hours after death. Funeral Director: After this certific tely filled in by the funeral director,	Certification; 7	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injur (Month, Day		28b. Tim Injui	e of	28c. injury at Work?	2 □ No	28d. Describe			
Ž	itat or Attendurs after deatl	Certifi	4 Homicide determined	28e. Place of Inju building, etc	ry - At ho . (Specify	me, farm,	street, facto	ry, office		28f. Location (City or To	Street and wn, State,	d Number or R)	ural Route Number,
	To the Hospitat or within 24 hours after To the Funeral Dir completely filled in	edical	29a. Certifier (Check only one) 1 Certifying Ph 2 Medicel Exem	ysician: To the best o liner: On the basis of and manner stat	examinat	wledge, do ion and/o	eath occurre r investigatio	d at the time, on n, in my opinio	late and place on, death occu	e, and due to the urred at the time,	cause(s) date and	and manner a place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	mi,	141		2	OC License nu	mber 1000		4	e signed (Mon	28
(2×1		30. Name and address of person who	completed cause of de	ath (Item	23a) (Ty	ge, Print)	lipre	e Ca	en C	all	ouro	ille Ma
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 1 2008	32. Registra	r's Signat	ure	Mil						2/228

08-02330 Robert Long

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 10409

bert Long		- For State Control yield and Department of Theatening Certificate of Dea	th	Reg. N	lo	
Physicia	ın/	Decedent's Name (First, Middle,Last)		2. Date of Death Month Da March 24, 20	y Year	3. Time of Death 1028 hrs
l Exami	_	Robert Wayne Long 4a. Facility Name (if not institution, give street and number) 4b. City,	Town, or Location of Dear		4c. County of Deat	h
		4a. Facility Name (ii not institution, give substantial	imore		N/A	
Funeral		5. Social Security Number 0. Ook	der 1 Year If Under 24H			rthplace (State or Foreign ountry)
Director		215-92-2752 1 XM 2 F 36 Yrs. Mon	ths Days Hours M	Nov. 7,	1971	MD
	L-	Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location				10d, Inside City Limits
w any	ŀ	100. State	Baltimore			1 X Yes 2 No
yland P-f sho	ğ	MD N/A 10e. Street and Number 10f. Z	Zip Code	10g.	Citizen of What Cou	untry?
; MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hyggiene. teath and Mental Hyggiene. Them 27 is marked other than "matural", or items 23a or 28a-f show any traumatic event, the Medical Examiner must be notified at once.	Director	2722 Wilkens Avenue	21223		United	States
with the ns 23a	lal	If Voc che	dent of Hispanic Origin? (Specify Yes or No-	14. Race - Ame White, etc.	rican Indian, Black,
death ir iten	Funeral	1 X Never Married 2 Married 1 Yes 2 X No	No specify:	no radan, didiy		ite
after ral", c	ğ	or Dates:	al Occupation (Give kind of	of work done 16	Specify: 6b. Kind of Business	s/Industry
hours "natu	ted	Elementary/Secondary (0-12) College (1-4 or 5+)	vorking life. DO NOT use r	retired)		
136 hin 72 e. than dical	ompleted	8 Brick	,			ruction
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiew. In Department of Filem 27 is marked other than "natural" injury or other traumatic event, the Medical Examine	S	17. Father's Name (First, Middle, Last)	18.Mother's Na	_{ime (First, Middle, Mai} ce Marie R	den Surname) emmert	
121! be fill ental F arked vent, i	Be	Carl Henry Long	ess (Street and Number			ite, Zip Code)
D 2'should and Mala Mis may is may matic e	2		Ave., North			
, MD and 2 sho ealth and iem 27 is		20b. Place of Disposition (N	Name of cemetery,	Date 2	20c. Location - City	or Town, State
Baltimore, permit. Pages I at Department of He Important: If ite		1 X Burial 2 Cremation 3 Removal from State Clerror Havenia 4 Departion 5 Other Specify: Memorial Par		-29-2008	Glen Bur	mie. MD
Itim iit. Pa artmer ortani		21. Six lature of Funeral Solvice Licenses (), 22. Name a	and Address of Facility Ar	mbrose Fun	eral Home	, Inc.
Balt permit. Depart Import		1 () () () () () () () () () (Sulphur Spr	ing Rd., A	rbutus, N	1D 21227
hysician		23a Part I. Enter the disease, or complications that caused the death. Do not enter the mod failure. List only one cause on each line.	de of dying, such as cardia	ac or respiratory arres	t, shock, or neart	Approximate Interval Between Onset and Death
Vedical xaminerے		Immediate Cause (Final disease a. Gunshot Wounds (2) of Head				Death
		or condition resulting in death) Due to (or as a consequence of):				
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated control receipting in death). Last Due to (or as a consequence of):				
ansit	Ä	events resulting in death) Last Due to (or as a consequence or).				
execuian an	Medical	UNPENDED AMENDED				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. The the Pureral Director: After this certificate has been signed by the attending physician and commetely filled in white fineral director, page 2 should be detached for use as the burial-transit.	Mec.	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the	ath 3 Ectopic pre	eanancy	23d. Date of deliver Month	very Day Year
Box 687 e death certific the attending p ed for use as th	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal decedent pregnant at time of death 5 Other (\$1.50)		egriancy		
BOX death	S	1 Yes 2 No 9 Unknown g Unknown				to the serves of death?
P.O. E es that the digned by the	효		lying cause given in Part I.			to the cause of death? Probably 4 Unknown
cords, P.O. law requires that has been signed b					n 124b. Were	autopsy findings available
ords w requisible bear	ğ			autops perforr	y prior	to completion of cause of
Reco	Completed			1 🗸 Yes 2		Yes 2 No
Division of Vital Records, tal or Attending Physician: The law requirers after death. After this certificate has been sited in by the funeral director, page 2 should be led in by the funeral director, page 2 should be	Be	25. Was case referred to medical	26.Place of Death (Ch ✓ DOA Other		Residence 6 0	ther:
F VII Physic er this	₽	1 V Yes 2 No Injury 28b Time of Injury 28b Time of Injury	7 30	28d. Describe h	ow injury occurred	
n of Niding Ph	i ii	1 Natural 5 Pending FOUND:	1 Yes 2 V No	Subject shot		
IVISION or Attend after death. Director:	icat	2 Accident Investigation 28e. Place of Injury - At home, farm, street, fac	ctory, office building, etc.	28f. Location (S	treet and Number o	r Rural Route Number, City
DIVIS Divis Di	Certification:	3 Suicide 6 Could not be determined (Specify) Near train tracks		400 S. Stricker	r St, Baltimore, M	d
D To the Hospital Within 24 hours To the Funeral			at the time, date and place	e, and due to the cause	e(s) and manner as	stated.
To the Hos within 24 h To the Fur	Medical	(Check only 1 Certifying Physician: 16 the Best of high knowledge, death occurred to one) 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.		neg at the time, date a		(Month, Day, Year)
	Ž		29c. License number O.C.M.E.		March 25, 20	
		anesz:	J. 5.5.1VI.E.		33,34	
3		30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Stree	et, Baltimore, MD 2	1201		
	State	7 tild 1 to 5 to 1 to 5 to 5 to 5 to 5 to 5 to	<i>a</i> .			
Regi		Acres 10 Marie Mar				
DHMH 17 Rev 1	1/2001	ORIGINAL			OCME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1, Decedent's Name (First, Middle, Last) Day **Physician** 30 Kenne Liwe

4a. Facility Name (If not institution, give street and number) 05 iwe he 3 /Medical 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Parkville Baltimore Oak Crest 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2□ F 87 7/4/1920 Director Virginia 224-03-0728 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Parkville MAryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8820 Walther Blvd. Apt 4003 21234 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 4 Bace - American Indian. 11. Marital Status Black, White, etc. 1 ∏ Yes 2 ☐ No If Xes, Give Year or Dates: WW II 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: White þ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Arc Welder Steel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item Z7 is marked oth any injury or other traumatic event once. Nora Alderman Wilburn Lineberry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 Hutchins Ct. Havre de Grace MD 21078 Mr. John R. Lineberry 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 15 Burial 2 Cremation 4 Donation 52 Other (S 3 ☐Removal from State 57 Other (Specify) 3/31/2008 Elkridge, Maryland Meadowridge Memorial neral Service Licenses 22. Name and Address of Facility 21. Signature of E Duda-Ruck Funeral Home of Dundalk, Inc. 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Ena /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any second to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autonsy perform 1□ Yes 25. Was case referred to medical Be Certification: To

attending physician and for use as the burial-trar P.O. þ Records, has page 2 certificate Vital 0 Division

INCORP.

Baltimore, Maryland 21215-0036

After 1 hours a er death 24 hours a er death e Funeral irector:

within 2 15+1 State

Medical

Hospital

		20:11000 01 000	att (Oneok only one)
examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp	eatient 3 DOA Other: 4 Wursing H	lome 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Beath 1 □ Natural 5 □ Pending 2 □ Accident investigat	ian	me of 28c. Injury at work? M 28c. Injury at work? 1 □ Yes 2 □ No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not determine		n, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
			e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)
on Circulus and title of contifier		29c Nicense number	29d Date signed (Month Day Vear)

30. Name and address of person who completed cause of death (Item 3. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	For State	State	of Maryla		artment of H			giene Reg. No. 2	008	10411
			Registrar Decedent's Name (First, Middle)	e, Last)					2. Date of De	ath		3. Time of Death
	Physicia		Ernest Lackey,						Month March	30, 20)08	1453 M
	/Medic Examin		4a. Facility Name (If not institution	n, give street and n	umber)		4b. City, Town, or	Location of Deatl		4c. Cour	nty of Death	
			Anne Arundel M	edical Co	enter		Annapoli				Arund	
4-2	Funeral		5. Social Security Number 403-22-4482	6. Sex 1 🔀 M 2 🗆 F	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	y, Year)	9. Birth Cou Kent	place (State or Foreign Intry)
a c	Director	-	Usual Residence of Decedent		84				Feb. 6,	, 1924	Kenc	иску
	land ow		10a. State 10b. County			City, Town or Lo						10d. Inside City Limits
	Mary a-f sh ffed a	to	Maryland Anne	Arunde1	1	Millers	ville					1 ☐ Yes 2X No
	th the or 28s	irec	10e. Street and Number				10f. Zip Code 2110	10		10g. Citizen o	of What Cou	intry?
	23a dust b	la l	1303 Alta Vista								Race - Ameri	an Indian
٥	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	11. Marital Status 1	ried Armed	ecedent Ever in Forces? s 2 No Give		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	Ilspanic Origin? (S an, Mexican, Puer Specify:	to Rican, etc.)		Black, White, Wh	
3-003p	hours ural",	d by	3 Widowed 4 Divorced	Year or	Dates: 194.		dent's Usual Occup	ation		16b. Kind of		ndustrv
0	n 72 l "nat edica	olete	(Specify only highe			(Give	kind of work done	during most of wo	rking			
7 7	withi	Completed	Elementary/Secondary (0-12) 12	College	(1-4or 5+)	Bus	Driver T	rainer		Trans	portat	10n
and	be filectal Hyg	Be C	17. Father's Name (First, Middle,	, Last)				18. Mother's Na Maude Wa	me <i>(First, Middle</i> ade	, Maiden Surr	name)	
<u> </u>	d Men marke	٥	Ernest Lackey 19a. Informant's Name/Relations	ship (Type Print)		19b Mailii	na Address (Street			per. City or Toy	vn. State. Zi	ip Code)
<u>a</u>	id 2 sl Ith an 27 is r traur		Lula Mae Lackey		fe		Alta Vis					21108
a)	s 1 ar f Hea item 3		20a. Method of Disposition		20b		osition (Name of matory or other place		Date	20c. Locatio		Town, State
e E	Page lent o nt: if iry or		1 ⚠ Burial 2 ☐ Cremation 4 ☐ Donation ﴾ Other (5		m State	Crownsv	rille	4/2				, Maryland
Baltimor	permit. Departminimorta Importa any inju		21. Signature of Funeral Service	Licensee	1101	29/) Fi	2. Name and Addre ineral Ho 530 Edmon	ss of Facility St me of Ca	erling tonsvil	Ashton le,Inc consvil	Schwal 1e. M	b Witzke D 21228
	10 march		23a. Part1. Enter the dis- se, o	r complications tha	at caused the de							Approximate Interval Between
	Physician		shock, or heart failue. Lis Immediate Cause (Final disease or condition	a a		reumoni	a					Onset and Death Weeks
	/Medical Examiner		resulting in death)	Due	to (or as a cons	equence of):						
	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) that initiated events	b. Due	to (or as a cons	equence of):						
p.	death certificate be executed e attending physician and of for use as the burial-transit	Examine	that initiated events resulting in death) Last	c	to (or as a cons	equence of):						
8760,	be ey sician buria	E E			•							
28	ficate physis the	edical		0								
ROX	h certi	In/M	IF FEMALE: 23b. Was decedent pregnant		outcome pf prec		□Ectopic pregnanc	v		23d.	Date of deli	
o.	that the death certificated by the attending posterior and detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pre	egnant at time o		Other (specify)				Month	Day Year
1	hat th		Part II. Other significant condit	ions contributing to	death but not r	esulting in the u	ınderlying cause giv	ven in Part I.	23e. Did	tobacco use o	contribute to	the cause of death?
Vital Records,	w requires that the sbeen signed by the should be detache	d by							1	Yes 2 ⊠ N	o 3∏Pro	obably 4 Unknown
O O		Completed							24a. Was	s an 24	4b. Were au	topsy findings available completion of cause of
ř	sician: The law certificate has l irector, page 2 s	mo I								formed?	death?	
<u>Ta</u>	ian: rtifica	Be C	25. Was case referred to medica examiner?	al				· · · · · · · · · · · · · · · · · · ·	eath (Check only	one)		
	hysic his ce I direc	To E	1 ☐ Yes 2 🔀 No			☐ ER/Outpatie		4 🗀 Nursing	Home 5□Res			cify)
Division or	ling P After t funera		27. Manner of Death 1 Natural 5 ☐ Pendi		ate of Injury fonth, Day Year,	28b. Time of Injury	Wo	ryat rk?]Yes 2 □ No	28d. Describe	how injury oc	curred	
Sic	death ctor: y the f	icat	3 Suicide 6 Could	not be 28e. Pla	ace of injury - A	l t home, farm, st	treet, factory, office	7,00 2,000			u <i>mber</i> o <i>r R</i> u	ıral Route Number,
2	s after ai Dire	Certification:	4 Hornicide	, DC	ilding, etc. (Spe					own, State)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	edical	29a. Certifier 1 Certifyi (Check only one)	ing Physician: To al Examiner: On the and m	the best of my le e basis of exam nanner stated.	knowledge, dea ination and/or i	th occurred at the t nvestigation, in my	ime, date and plac opinion, death oc	ce, and due to the curred at the time	e cause(s) and e, date and pla	d manner as ace, and due	s stated. to the cause(s)
	To # within To #	Me	29b. Signature and title of certific	Januar B	ech, H	0	29c. Licen	746052	-	29d. Date si	gned (Mont)	h, Day, Year) b
,	,0X1		30. Name and address of person	n who completed c	ause of death (I	tem 23a) (Type	Print) Poul	way an	mapolis	, Mus		
		ate	31. Date filed (Month, Day, Year	1 2008	2. Régistrar's Sig	gnature	harle					
	Regist	rar	HI II	1 1000	7.5							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Vear **Physician** 415AM 2008 /Medical 4b. City, Town, or Location of Death 4c. County of De 4a. Facility Name (If not institution, Examiner Bostimore lmor If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number (In vrs. last birthday) **Funeral** Min. 86 Months Days Hours North Carolina Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f shov notified at 1 Nes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be i Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. nit. Pages 1 and 2 should be filed within 72 hours after or artment of Health and Mental Hygiene. ortant: If Item 27 Is marked other than "natural"; or Itel Injury or other traumatic event, the Medical Examiner 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Blac 1 ☐ Yes 2 ☐ No 3altimore, Maryland 21215-0036 Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be ျှ daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Southworth Owen 20a. Method of Disposition 20b. Place of Disposition (Name of crematory or other place 1 Surial 2 □ Cremation 3 Removal from State 31 Department o Important: If any Injury or Wordlawn 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 5 days **Physician** ulmonary /Medical Due to (or as a consequence of): **Examiner** Cerebral Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 donknown 1 ☐ Yes certificate has been si rector, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform Hypertension 1☐ Yes 2 DING To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ funeral 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation Volume To the Funeral Director: Aff 1∐Yes 2∐No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 1 Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 261 Cost University Parkway Upion Memorial the

State Registrar

guyen, M.D

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 16:42 M McCaden Jr. 30 2008 Roland Reid 03 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4316 Eldone Road Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex Date of Birth (Month, Day, Year) **Funeral ™** M 2□ F Months Days Hours Director 07 24 218-46-9405 61 46 MD Usual Residence of Decedent 10c. City, Town or Location show 10a. State 10b. County 10d. Inside City Limits at MD NA Baltimore 1 X Yes 2 □ No be notified Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with Hygiene. 6 21229 4316 Eldone Road U.S.A. items 23a must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 "natural", or 1 ☐ Yes 2√√ No Specify: Black Specify: by 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Johns Hopkins than, Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event, the once. the Custodian 12th_grade Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Roland R. McCaden Sr. Beulah Hawthorne 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21229 731 South Woodington Road, Baltimore, Lorraine Brown-Sister Md Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park 4/4/08 Arbutus, Md 21 Signal te of Funeral Service Licensee 22. Name and Address of Facility March F/H West 21215 4300 Wabash Ave, Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death i media a Cause (Final di east or condition res l'ing in death) **Physician** Year S /Medical Due to or as a consequence of): Examiner arcoldosi Sequentially list conditions, if a 1y, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Directo for as a consequence of: physician and s the burial-transit be exect Due to (or as a consequence of): Box 68760, Physician/Medical as attending IF FEMALE asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy jo in the past 12 months? Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a Id be detached for 1 ☐ Yes 2 ☐ No o 9 Unknown ٦ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, Completed by Imman 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 24a. Was an has e 2 autopsy page perform None certificate 1□ Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 27. Manner of D at Hospital: Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 5 Residence 6 □Other (Specify) this funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Attending 5 ☐ Pending investigation after death. I Director: A d in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ö To the Hospital within 24 hours a To the Funeral I the certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier completely (Check only one) and manner stated 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year)

7

State Registrar 31. Date filed (Month, Day, Year)

APR 0 1 2008

ar's Signature

000

of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2008 Thora M. Mengers 30, 3:10 A^M March /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Renaissance Gardens Catonsville Baltimore 8. Date of Birth (Month, Day, Year) Oct 19, 1913 5. Social Securify Number if Under 1 Year | if Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthdav) **Funeral** Months Days Hours 1 □ M 2 💢 F 212-05-7881 94 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 XNo Directo Baltimore Catonsville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 719 Maiden Choice Lane 21228 **USA** Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White þ 3 Nidowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be filed be Department of Health and Mental Hygis Important: If item 27 is marked other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gustav W. Eklof Carrie Strouse 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Mengers, Son 38 Montvieu Court Cockeysville, Maryland 21030 or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Injury o Good Shepherd Cemetery 04/05/08 4 ☐ Donation 5 ☐ Other (Specify) Ellicott City, MD 21. Signature of Funeral Service Inconsee

Thomas Gregor MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, Maryland 21228 É 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ierebral vascular disease 20US disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if an, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed attending physician and for use as the burial-transit and Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) P.O. signed by the a 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 o this funeral 28a. Date of Injury (Month, Day Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: To the Hospital or Attending within 24 hours after death. Division 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D3098 March 30 2008

State Registrar 30. Name

DHMH 17 Rev 1/2001

711 Maiden Choice Ln Obtonsville Mr

nd address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

M Carpenter

filed (Month, Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend #10e Per FH G878 4/01/08call of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MORGAT 2008 2.00 AM /Medical 4c. County of Death Pacility Name (If not institution give street and flumber) 4b. Ohv. Town, or Location of Death Examiner rk Nursing Home Baltimore atonsuille 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year, 10-13-19 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Days Hours 1 ☐ M 2 🕶 F 106 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a, State 10c. City, Town or Location show 1 Yes 2 No ral', or items 23a or 28e-f sh Exercit at roust be notified licot Funeral Director Howar 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 2 any injury or othar traumetic evant, the Medical Exercit art is usat be 11 once. bardens 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married imore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 151ack Completed by 3 Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, QO NOT use retire!) (Specify only highest grade completed) condary (0-12) College (1-4or 5+) omesti 17. Father's Name (First Middle, Last) Dray 2 (Relationshi (Type, Print) 19b. Mailing Address (Street and Number leming (Niece 11621 Columbia, MD 21044 Clarksville, onD 20b. Place of Disposition (Name of 20a. Method of Disposition 1XBurial 2 ☐ Cremation 3 ☐ Removal from State Columbia Memoria 4 ☐ Donation 5 ☐ Other (Specify) cene Funeral Services 21. Signature of Funeral Service Pile (21229) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Win /Medical Due to (or as a consequence of): Examiner WK Sequentially list conditions, any, loading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Dualto (or as a consequence of): The law requires that the death certificate be executed Box 68760,免 that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical nse 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Day Year 0 4☐Pregnant at time of death 5 Other (specify) P.O. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Whiknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 □ No 1 TYes 2 NO ivision of Vital To the Hospital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Turning Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No s after death. Il Director: After this id in by the funeral d 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Medical Certification: 1 Natural 5 Pending investigation 1 Tes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 TSuicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 6 30. Name and address of person/who complete RAK41A

Registrar DHMH 17 Rev 1/2001

State

Neola

Caferjuith, no

erson/who completed cause of death (Item 23a) (Type, Print)

32. egistrar's Signature

009,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Item 1 per dr., g878, 04/01/03dbb f Death

Reg. No. Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Walter Matthews Month Physician 0 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death **Examiner** General 8. Date of Birth Month, Day 1722 If Under 1 Year | If Under 24 Hrs. . last birthday 9. Birthplace (State or Foreign Funeral Days Hours Min Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show Baltimore 1 Yes 2 □ No r 28a-f sh notified Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street an Number or pe r items 23a c Completed by Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1X Never Married 2 ☐ Married 1 ☐ Yes 2 1 If Yes, Give Year or Dates: 2 No 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 "natural", or 3 Widowed 4 Divorced er than "natura , the Medical E 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done life. DO NOT use retire College (1-4or 5+) condary (0-12) is marked other To Be 19b. Mailing Address (Street and Number or 608 permit. Pages 1 and 2: Department of Health at Important; If Item 27 is any injury or other trau once. 20b. Place of Disposition (Name of cemetery, crematory or other 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specific) Baltimore, 21. Signature of Funer Service 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attending physician and Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death Month Day in the past 12 months? completely filled in by the funeral director, page 2 should be detached for ☐Yes 2☐No To the Funeral Director: After this certificate has been signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 8 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check onl. one Be Other: 4 Nursing Home Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) Euleu 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 0 1 2008

DHMH 17 Rev 1/2001

Registrar

P.O. Box 68760. Division or Vital Records, Hospital or Attending Physician: within 24 hours at To the Funeral E completely filled To the

> State Registrar

31. Date filed (Month, Day, Year) APR 0 1 2008

KSharma Grag

29b. Signature and title of certifier

1500 Forrest Glen Road Silver Spring MD 20190 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D60826

29d. Date signed (Month, Day, Year)

03/21/2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Edward R. 2128 PM Meehan 3 23 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore FRANKLIN Square Hospital Center Rosedale If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Days 1√2 M 2□ F 220-20-2725 80 Director 1/18/1928 Maryland Usual Residence of Decedent 10c. City, Town or Location show 10a. State 10b. County 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Baltimore Bowleys Ouarters 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1221 Seneca Road 21220 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: ↓ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced WWII White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1 Marketing Verizon Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Meehan permit. Pages 1 and 2 shou Department of Health and M Important: if item 27 is mar any injury or other traumat 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1221 Seneca Road Bowleys Quarters, MD 21220
of Disposition (Name of Date 20c. Location - City or Town, State Nona G. Meehan/ Wife Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 3/28/08 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck F.H. of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** respiratory failure / metabolic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner effusion eural Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to ror as a consequence of Examiner death certificate be executed burial-transit eTasTaTic physician s s the burial-P.O. Box 68760 Physician/Medical as attending for use a IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate l 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🔲 Yes 2 ER/Outpatient ၉ 1 Inpatient 3□ DOA this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rura Fruite Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division or Vital Records,

Registrar

State

Medical

29a. Certifier (Check only one)

29b. Signature and title of certifier

DR AMY KOKOTAKIS 31. Date filed (Month, Day, Year)

APR 0 1 2008



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Sauare DR

29d. Date signed (Month, Day, Year)

Baltimore md 21237

3-23-2008

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician:

within 2

State Registrar

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 EASTERN AVENUE

and manner stated.

. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

BALTEMORE MD 21224

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month. Dav. Year)

DHMH 17 Rev 1/2001

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

6 ☐ Could not be

APR 01

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

RES-000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Nø. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 Year **Physician** March 28, Nora Amalee Mohr 8:40PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Heritage Nursing Home Baltimore Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Oction, Bay, Year 1925 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 215-24-9432 1 □ M 2 1 F 82 Director West Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. Cify, Town or Location 10d. Inside City Limits MD N/A Baltimore be notifled ₩ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1701 Charlotte Avenue 21224 U.S.A. Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced Specify: White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Factory Worker Sewing Factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gilbert Lee Metz Underwood Grace Item 27 Is marke other traumatic ۵ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Kosmaczewski/Daughter 1701 Charlotte Avenue Baltimore, Maryland 21224 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If It any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 4/2/08 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck F.H.of Dundalk, 7922 Wise Avenue Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. CARDIOVASCULAR DISEASE Immediate Cause (Final RIOSCLEROTIC Physician disease or condition resulting in death) /Medicai Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as e consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and use as the burial-transit Due to (or as e consequence of) Division or Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMINARY DIS 23e. Did tobacco use contribute to the cause of death? Certification: To Be Completed by DUSEAS 2 No 1 Tyes 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed?

1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature 29c. License number 4160 29d. Date signed (Month, Day, Year) MARCH28, 200 Gusto de Aprilio 1838) (500-19110 - A RITCHIE HIGHWAY)

State Registrar 31. Date filed (Month, Day, Year)

APR 0 1 2008

DHMH 17 Rev 1/2001

Registrar's Signature

Physician /Medical

1 - For State Registrar

1. Decedent's Name (First, Middle, Last)

Arlene D. Mills

	Examir	ier	Keswick Multi-Care Center Baltimore									N/A					
	Funeral Director		5. Social Security 175–16–83	12	6. Sex 1 ☐ M 2 ဩ F		-	st birthday) Yrs.	If Unde Months	r 1 Year Days	If Unde Hours	Min.	8. Date of B 06/04/1	idh () 910 ea	r)	Co	hplace (State or Foreigi untry) NSYIVania
	and w		Usual Residence of 10a. State	10b. County		1	0c. City,	Town or Lo	ocation								10d. Inside City Limits
	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Director	MD	N/A			Bål	timore									1 ⊠Yes 2 □ No
	3a or 2	al Dir	10e. Street and No		e Apt. 102)			10f. Zij					_	Citizen of \	What Co	ountry?
	deatl	Funeral	11. Marital Status	J-1.1-	12. Was D	ecedent Eve Forces?	er in U.S.	. 13.			lispanic C	rigin? (Sp	ecify Yes or N Rican, etc.)		14. Rac		rican Indian,
9	after or Ite			rried 2□ Marr		s 2 No		i	1 ☐ Yes		Specifi		nican, etc.)			ck, Whit	
8	ural"; Il Exa	d by	3 Widowed	4 Divorced	Year o	r Dates:										√ Whi	
5	n 72 l "nat edica	ete			r's Education of grade complete	ed)		16a. Dece (Give	dent's Usu kind of wo DO NOT u	ial Occup ork done ise retire	ation <i>during mo</i>	st of work	ing	16b.	Kind of Bi	usiness/	Industry
Baltimore, Maryland 21215-0036	d withii giene. ir than the M	Completed	Elementary/Sec 12	ondary (0-12)	College	e (1-4or 5+)			rwrite		<i>a)</i>			Ins	suranc	e	
b	al Hygi l other vent, t	Be C	17. Father's Name	(First, Middle,	Last)						18. Moti	ner's Name	(First, Middl	e, Maide	en Surnan	ne)	
<u>ya</u>	2 should be filed and Mental Hygid Is marked other anmatic event, the	2	Cornelius	A. Diehl							Sara	E. Hi	llegas				
lar	2 sho		19a. Informant's N	Name/Relations	nip (Type. Print)								al Route Num				Zip Code)
es of	ges 1 and 2 should it of Health and Mer If item 27 is marke or other traumatic				, Daughter	•	20h Bla						altimore Date				
ŏ	it of h			Cremation	3 □ Removal fro	om State		nce of Dispo metery, cre								-	Town, State
計	it. Pa		4 ☐ Donation 21. Signature of F	5 Other (S			Parki	wood Ce	emetery 2. Name a			03/31/		1	timore	,)
Ba	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of F	esons		20.							onard J. imore, M		•	•	
			23a. Part1. Enter	the disease, or	complications the	at caused th	ne death.								_1		Approximate
	Physician		Immediate Cause disease or conditi	(Final on	only one cause of	m each line. Meat											Interval Between Onset and Death
	/Medical Examiner		resulting in death)		to (or as a o											Vanha
60,	that the death certificate be executed ed by the attending physician and a detached for use as the burial-transit	al Examiner	Sequentially list of fany, leading to it cause. Enter Und Cause (Disease of that initiated even resulting in death)	onditions, mmediate erlying r injury ts Last	Due c	to (or as a c	conseque	ence of):	0 02.00	lsiu							revue
Box 68760,	certificate nding phys use as the	Physician/Medical	IF FEMALE: 23b. Was decede	nt prognant	23c. If yes,	outcome pf	pregnan	су							23d. Da	te of de	livery
P.O. Bo	the d	hysicial	in the past 1 1 ☐ Yes 2 9 ☐ Unknow	2 months? ☑ No	4□Pr	ve birth 2 egnant at tir iknown			⊒Ectopic p ⊒ Other (s		y 					onth	Day Year
Ś	The law requires that te has been signed bage 2 should be deta	by	Part II. Other sign	ificant condition	ons contributing to	death but	not result	ting in the u	ınderlying	cause giv	en in Par	t I.			o use con 2 □ No	-	o the cause of death? robably 4 □Unknowr
or Vital Record	10 20	Completed											24a. Wa	s an opsy	24b.	Were a	utopsy findings available completion of cause of
<u> </u>		E C												formed?	?	death? 1 ☐ Yes	
/ita	sician: Th certificate rector, pag	Be (25. Was case refe examiner?	erred to medica						Tau		ce of Deat	h <i>(Check only</i>	one)			
or	Phys this al dir	2	1 ☐ Yes 2 ☐ 27. Manner of Dea	₩o ath		Inpatient		R/Outpatie		UA _		Vursing Ho			6 □Oth		ecify)
O	ffer ne	ion	1 ☑Natural	5 ☐ Pendin investi	g (N	ate of Injury fonth, Day		Injury	M	28c. Inju Woi	ryat rk? Yes 2[28d. Describe	e now in	jury occur	rea	
Division	or Attending after death. Director: After in by the fune	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could	not be 28e. Pl	ace of injury illding, etc.	/ - At hon (Specify)	ne, farm, st			163 2		28f. Location City or T			ber or R	ural Route Number,
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	ledical C	29a. Certifier (Check only one)	1 ♥ Certifyir 2 ■ Medical	g Physician: To Examiner: On th and m	the best of e basis of e nanner state	xaminatio	rledge, dea on and/or in	th occurred	at the ti	me, date opinion, d	and place, eath occur	and due to the	e cause e, date a	(s) and m and place,	anner a and du	s stated. e to the cause(s)
	Го th within Го th	Me	29b. Signature an	d title of certifie					29	c. Licens	se number	,		29d. E	Date signe	d (Mon	th, Day, Year)
			D77€	abelle V	Tac 9	ega	My			D13	657	7		Tar	reh o	28,	2008
	10		30. Name and add	dress of person	who completed c	ause of dea	th (Item 2	23a) (Type, W - 4	Print)	TRE	BT, O	BALT	7172 RE	, 0%	7212	211	
	Sta Regist	ite rar	31. Date filed (Mg	PR 0 1	2008	Hegistrar	s Signatu	ire An	and s								
DH	IMH 17 Rev 1/2	001															
								OF	RIGINA	L							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Date of Death Month

26 Day

8:00

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Alice McKinney 2008 8:30 March /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Upper Chesapeake Medical Center Harford Bel Air If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 M 2 F 182-01-5202 90 14, 1917 Pennsylvania Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medral Examiner must be notified at 1 ☐ Yes 2 ☐No Director PA Berks Wvomissing 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 19610 USA 2512 Providence Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █No If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☑ No Specify þ 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled w. Department of Health and Mental Hygien important; if Item 27 is marked other the any injury or other trainmast. Own Home 10 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Daisy C. Spencer James F. Leininger ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2512 Providence Road, Wyomissing, Pennsylvania e of Disposition (Name of Date 20c. Location - City of Town, State Beverly M. Chick / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Buria 2 4 ☐ Donation 2 ☐ Cremation 3 ☐ Removal from State 3-26-08 Shillington, PA Fairview Cemetery 5/DOther (Specify) 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Sign, ture of Fundal Scryice Licensee 1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and Death Part1. Enterthe disease, or complications that caused the death. shock, or heart failure. List only one cause on each lin-Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine as the bunal-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1□Yes 2□No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the a page 2 should be detached 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ MO 24a Was an autopsy 1□ Yes 2 - 100 completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Inpatient 1 🗆 Yes 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day Year) 27. Many er of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: To the Funeral Director: After 1. Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide determined 1 Locartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 24 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

APR 01

M8004503(

30. Name and address of person who completed cause of teath (Item 23a) (Type, Print)

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Christian Frederick Morlok Sr. March 12:55 PM 28, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1XIM 2□ F Months Director 216-12-5414 89 1918 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthen "natural", or iteme 23s or 28s-f ehow the Medical Examinar must be notified at 1X Yes 2 No Director Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 319 Edmund St. USA 21001 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Deperment of Health and Aloued be filed within Deperment of Health and Mental Hygiene. Important: if item 27 is marked other then eny injury or other traumatin Elementary/Secondary (0-12) College (1-4or 5+) 12 Parts Counterman Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Christian Lewis Morlok Nellie Lavinia Elv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth K. Morlok / Wife 319 Edmund St., Aberdeen, MD 21001 Itimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State to Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Ottper (Specify) Paul's Lut. Cem. 3-31-08 Aberdeen, Maryland 21. Signature of Funeral ervice co es Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 and 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) iration **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Die to (or as a consequence of): ulle Due to for as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) signed by tha a d be detached for of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Dementia 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed kensons 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has performed? 1 ☐ Yes 2 No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Ninpatient 2 ER/Outpatient 3 DOA ၉ ihis Director: After this in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Injury 27. Manger of Death 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident 5 Pending investigation death 1 Tes 2 No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Thomicide within 24 hours a

To the Funerel I

completely filled pelli Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

State Registrar 29b. Signature and title of certifier

31. Date filed (Month,

30. Name and address of rson who completed cause of death (Item 23a) (Type, Print)

ucmc

32. Registrar's Signature

DO06582+

500 Belar mo

29d. Date signed (Month, Day, Year)

08-02275	al B.4.	Please Type or Print in Black Indelible Ink. Ensure All Copi			
William Raymon		larshall State of Maryland / Department of Health and Mental H		200	08 1042
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)	2. Date of Death	. No.	3. Time of Death
Medical Exami		William Raymond Marshall	Month I March 22, 2	Day Year 2008	1730 hrs
d'		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Dea	ith	4c. County of Deat	n and a second
		152 & Franklinville & Taylor Road Joppa		Harford	11. 1 (01
Funeral	- 1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24F Months Days Hours M	lin.	(MM/DD/YYYY) 9. Bi Forei	gn
Director		218-06-8141 K M 2 F 33 Yrs.	Feb. 1	5, 1975 °	ountry) Maryland
any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
р мог		Maryland Harford Fallston			1 Yes 2 Xio
nrylan 15 Sa-f sl	횽	10e. Street and Number 10f. Zip Code	100	g. Citizen of What Cou	intry?
he Mi	Director	735 Reckord Road 21047		USA	
with the same	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (rican Indian, Black,
death rr iten	nue	1 XNever Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puel Yes 2 No	no Rican, etc.)	vvinte, etc.	
after affer iner	Ą	3 Widowed 4 Divorced If Yes, Give Year or Dates:			hite
hours natur Exam		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use r		16b. Kind of Business	rindustry
36 in 72 han "	bet	Elementary/Secondary (0-12) College (1-4 or 5+) 12 Floor Installer		Flooring	
5-0036 iled within 7. Hygiene. I other than	Completed	17. Father's Name (First, Middle, Last) 18. Mother's Na	me (First, Middle, M		
Baltimore, MD 21215-0036 Permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itien 27 is marked other than "natural", or items 23a or 28a-f show injury or other tranmatic event, the Medical Examiner must be notified at once.	Be	Maurice Raymond Marshall Carol	yn Louise		
21; ould by Men	인	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of			
MD d 2 sho lith and n 27 is		Ray Marshall / Father 1201 Cloverfield Co		Air, MD 21	
re, s l an f Hea If iter		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City t	r Town, State
Baltimore, permit. Pages I an Department of Hea Important: If ite		4 Doghation 5 Other Specify: Hilltop Service Corp. 3		Towson, N	iaryland
Salti ermit. epartn nport ijury		21. So ture of Fun - a Se - e Licens - 22 Name and Address of Facility - 21. So ture of Fun - a Se - e Licens - 22 Name and Address of Facility - 22 Name and Address of Facility - 22 Name and Address of Facility - 22 Name and Address of Facility - 23 Name and Address of Facility - 24 Name and Address of Facility - 24 Name and Address of Facility - 24 Name and Address of Facility - 25 Name and Address of Facility - 24 Name and Address of Facility - 25 Name and Address of Facility - 25 Name and Address of Facility - 25 Name and Address of Facility - 25 Name and Address of Facility - 25 Name and Address of Facility - 25 Name and Address of Facility - 25 Name and Address of Facility - 25 Name and Address of Facility - 25 Name and Address of Facility - 25 Name and Address of Facility - 25 Name and Address of Facility - 25 Name and Address of Facility - 25 Name and Address of Facility - 25 Name and Address of Facility - 25 Name and Address of Facility - 25 Name and Address of Facility - 25 Name and Address of Facility - 25 Name and Name	Home, P.A	١.	
		23 . Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia	oad, Abin	adon, MD 2	21009 Approximate Interval
Physician /Medical		failure. List only one cause on each line.			Between Onset and Death
₹ caminer	9. 0	Immediate Cause (Final disease or condition resulting in death) a. Carbon monoxide intoxication associated with Due to (or as a consequence of): cocaine intoxication	n narcotic (neroin) and	
•		h h			
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			
	Examiner	CDisease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
vecuted 1 and - transit		d			
e exec cian an	dical				
n of Vital Records, P.O. Box 68760, Jing Physician: The law requires that the death certificate be ex. After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial.	an/Medic	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delive	
687 certifications addings	ian/		gnancy	Month	Day Year
Box e death c the atten ed for us	ysici	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify)			
O. E lat the cd by the etached	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute	to the cause of death?
P.(d by		1 Yes	2 No 3 Pr	obably 4 Unknown
of Vital Records, ng Physician: The law requir the this certificate has been s meral director, page 2 should	Completed		24a. Was a		autopsy findings available completion of cause of
CO lee law lee has ge 2 sl	dm			med? death'	
IR ii: Th tifical or, pa		25. Was case referred to medical 26.Place of Death (Che			
/ita //ita //is cer is cer direct	o Be	augminor?	rsing Home 5	Residence 6 🗸 Ott	ner: Scene
ision of Vital Attending Physician: rdeath. ector: After this certifi by the funeral director,	-	27 Manner of Death 28a Date of Injury 28b, Time of Injury 28c, Injury at Work?			ubject inhaled
lon tendir eath.	ertification:	Natural 5 Pending Pending Investigation Fnd 3/22/2008 Fnd 5:20 pm 1 Yes 2 X No	vacuum o	cleaner -	pe of car via
Division tal or Attendin is after death.	ifica	3 X Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (S	Street and Number or state)	Rural Route Number, City
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Cert				Taylor Rd. Jopa
n Hos n 24 h e Fun letely		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, one)	and due to the caus	se(s) and manner as st and place, and due to	ated. the cause(s)
To the within To the comple	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated. 29b. Separature and title of certifier. 29c. License number	00 01 010 11110 1	29d. Date signed (#	
	×	MAN - DOCME		March 23, 200	
		mayine The state			
		30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, N	1D 21201		
	tate				
Regis		31. Date filed (Month, Day Year) 1 2008 32. Redistrar's Signature			

1 - State Registrar

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** William Mitchell Thomas 3:05 p March 30 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Towson Baltimore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex **Funeral** Months. Days Hours Min. 1 X M 2 ☐ F 214-24-4260 79 16, Director Dec. 1928 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, it a Modical Examinating in an table recitified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Funeral Director Md. Baltimore 1 ☐ Yes 2 ☑ No Towson 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 25 Ruxview Court Apt 102 21204 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 없Yes 2 ☐ No If Yes, Give Ye ar or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 🛛 No Specify: Completed by White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Paint & Chemical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Warren Mitchell Blanche. Foster ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25 Ruxview Court Apt 102 Mrs. Carolyn Mitchell/ Wife Towson, Md, 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any Injury or Moreland Memorial Pk. 4-4-08 Baltimore, Md. 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 23a. Part 1. Enter the diseable, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 0 CANCER Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, learning to infine flate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Die to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burish-transit completely filled in by the funeral director, page 2 should be detached for use as the burish-transit Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2 🗆 No 1 □ Yes 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Sother (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 1 Yes 2 No Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier address of person who completed cause of eath (Item 23a) (Type, Print) 30. Name an Centes St. Balto. Md 2120x 6 Bunc 6701 N. 31. Date filed (Month, Day, Year) #2. Registrar's Signature State APR 01 2008 Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

29b. Signature and title of certifier

B

Directo

Completed by Funeral

Be

2

Examine

Completed by Physician/Medical

Be 2

Certification:

Medical

Physician

/Medical

Examiner

Funeral

Director

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Physician

/Medical Examiner

Please T	• •		re All Copies Are Legible	
For State	State of Maryland / I	Department of Health a Certificate of Death	, 0	
Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of Death	Reg. No. 2	3. Time of Death
Amelia Lagma	ay Magboo		Month Day Yes	. 1.1 M
4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, or Location of		
Franklin Squar		ter Rosedale	Balt	imore
5. Social Security Number 6. Sex	™ 2⊠ F To Age (In yrs. last bit	Yrs. Months Days Hours	8. Date of Birth (Month, Day, Year) July 11, 1927	Birthplace (State or Foreign Country) Philippines
Usual Residence of Decedent			- Odfy 11, 152	
10a. State 10b. County 1	10c. City, Tow	imore		10d. Inside City Limits 1 ☐ Yes 2 X No
10e. Street and Number	e par	10f. Zip Code	10g. Citizen of What	
B424 Beldale Cou	rt	21236		States
11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican,	jin? (Specify Yes or No- , Puerto Rican, etc.) 14. Race - A Black, W	merican Indian,
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 MNo If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒No Specify:	Specify:	Asian
15. Decedent's Educ (Specify only highest grade		Decedent's Usual Occupation (Give kind of work done during most	of working	ss/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)	Office Clerk	City Go	vernment
17. Father's Name (First, Middle, Last)			's Name (First, Middle, Maiden Surname)	
Melecio Lagma	у	Mon	ica Pangramuyen	
19a. Informant's Name/Relationship (Type Maria Theresa Mag	gboo (daughter)		ror Aural Aoute Number, City or Town, Stat rt, Baltimore, Maryl	
20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	comoto	f Disposition (Name of ry, crematory or other place)		
4 □ Donation 5 □ Other (Specify)		Mem. Gardens		hilippines
21. Signature of Funeral Service License		1	Ruck Towson Funeral , Towson, Maryland	Home, Inc. 21204
23a. Pall1. Enter the disease, or complic shock, or heart failure. List only on	cations that caused the death. Do le cause on each line.	not enter the mode of dying, such as	cardiac or respiratory arrest,	Approximate Interval Between
Immediate Cause (Final disease or condition resulting in death)	Metastatic Due to (or as a consequence	Renal Cell C	arcinoma	Onset and Death
Sequentially list conditions, b		alls:		5
rany, learning to intributate cause. Enter Underlying Cause (Disease or injury	Due to (or se a consequence	Oi)		
that initiated events cresulting in death) Last	Due to (or as a consequence	of):		
d	•			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of Month	delivery Day Year
Part II. Other significant conditions con	tributing to death but not resulting i	n the underlying cause given in Part I.	23e. Did tobacco use contribute	e to the cause of death?
Anemia			1	Probably 4 Unknown
			performed? death	
25. Was case referred to medical		26. Place	1 Yes 2 1 No 1 1 Yes of Death (Check only one)	′es 2□No
examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 Inpatient 2 ER/Ou	Other:	sing Home 5 Residence 6 Other (S	Specify)
27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigation		Time of njury at Work? M 28c. Injury at Work? 1 Yes 2 N	28d. Describe how injury occurred	
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At home, fa building, etc. (Specify)	rm, street, factory, office	28f. Location (Street and Number of City or Town, State)	Rural Route Number,
29a. Certifier 1 ☐ CertifyIng Phys (Check only one) 2 ☐ Medical Examir	ician: To the best of my knowledger: On the basis of examination are and manner stated.	e, death occurred at the time, date and ad/or investigation, in my opinion, deat	th occurred at the time, date and place, and	r as stated. due to the cause(s)

29c. License number

53462

es MD, 9000 Franklin Square Drive, Baltimore MD, 21237

29d. Date signed (Month, Day, Year)

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

State Registrar Dr. Ju

ORIGINAL

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State amend #26 Per Phy G8/8 4/01/08 JH Gertificate of Death Reg. No. Reg. No. C 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 29, 2008 Mary Jane Maples 3:00 March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9047 Furrow Avenue Ellicott City Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☐ M 2 🗓 F 226-26-3275 30,1949 North Carolina Director 59 Jan. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County show items 23a or 28a-f shov Iner must be notified at 1 ☐ Yes 2 N No Vrrginia Chesterfield Chesterfield Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 10815 Trents Bridge Road 23838 death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or iter 1 Never Married 2 Married White altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify. 3 XWidowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health Care 10 Packaging Department 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florence Eva Huskey Alex Clarke Blanton ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17331 25 Nace Drive; Hanover, Pennsylvania Daughter Angela Weaver 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State Big Stone Gap, VA Powell Valley Mem.Gar: 4/4/08 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilly Sterling Ashton Schwab Witzke 21. Signature of Euneral Service Licenses Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, 140/490 MD 21228 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 Other (specify) been signed by the s 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has t lirector, page 2 s performed Yes or Attending Physiclan: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Daughter (Specify) examiner Other: 4 Nursing Home 5 Residence 1 Yes Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred Law's Home 27. Mann of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? After (Month, Day Year) Injury 1 atural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital l 🔛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature

Registrar
DHMH 17 Rev 1/2001

State

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Celsine

2008

31. Date filed (Month, Day, Year)

APR 01

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year FRANCIS MAIER 10,29 AM HARRY 26 MAR 2008 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) HOWARD COLUMBIA HOWARD COUNTY GENERAL HOSPITAL Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Months Days Hours 11XM 2□ F New York 1,1921 066-16-7180 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 X No Maryland Howard Columbia 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21045 U.S.A. 9116 Goldamber Garth Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. Tayes 2 No f Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐XNo Specify: White 3 XWidowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Optical Industry Marketing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Agnes L. Ruddy John I. Maier 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9116 Goldamber Garth Columbia, MD 21045 Richard Maier (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 3-29-2008 | Catonsville, MD Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servic Licenses Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, MD 21045 M01050 41 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Geominaton, day disease or condition resulting in death) Due to (or s a consequence of : ahuto locca Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Year Month Day 4☐ Pregnant at time of death 5 Other (specify) 2 □ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 22 No 1□ Yes

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Director

Funeral

δ

Completed

Be

2

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

death with the Maryland

within 72 hours after

than

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event

Baltimore, Maryland 21215-0036

burial-trar as the asn for detached page 2

director.

Physician/Medical þ Be Completed

Certification: To

Medical

29b. Signature/and title of certifier

31. Date filed (Month, Day Year)

7350

MD, FCCP

2008

more

32. Pagistrar's Signature

Les 1000

Crace

0 1

Examiner

this After

requires that the death certificate be executed

Physician:

P.O. Box 68760,

Vital Records,

0

Division Hospital or Attending

To the Hospin...
within 24 hours after death.
To the Funeral Director: A

Registrar

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23b. Was decedent pregnant in the past 12 months? 9 Tllnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cardioninosath 25. Was case referred to medical / examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🔀 Ño 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No M 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

29c. License number

36845

MD

Mar. 26, 2008

DHMH 17 Rev 1/2001

Columbra.

30. Name and didress of person who completed cause of death (Item 23a) (Type, Print) Man-Club Inguyen, MD, FCC P

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** harles March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Point System Maryland HEalth Care 5. Social Security Number
2/6-20-3755
Usual Residence of Decedent If Under I Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In rs. last birthday)
Yrs. Charles **Funeral** Months Days Hours Min 120 M 2□ F November 5, 1927 Director 10c. City, Town or Location 10b. County BAILIMORE 0 Director MARYland 10f. Zip Code 10e. Street and Number ms 23a or 7 2500 W. Beluedere 21215 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Dayes 2 □ No If Yes, Give Year or Dates:/946-/963 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 27 Is marked other than "natural", or iten traumatic event, the Medical Examiner 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Improvement grand Worker U.S.

18. Mother's Name (First, Middle, Maiden Surname) 121 Maryland 17. Father's Name (First, Middle, Last) s 1 and 2 should be fill if Health and Mental H item 27 Is marked oth Be SR Lillian Charles Midget P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Old Court 8801 20a. Method et Disposition Kaleigh Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) jo. Important: If it any Injury or conce. 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Doration 5 □ Other (Specify) 22. Name and Address of Facility

JANCY M. WATTACE FUNERAL ure of Funeral Service Licensee 340st W. FRANKLIN Street BAHLIMORE, MARYLAND 21229 elace 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he or failure. List only one cause on each line. Immediate Cause (Final Colon **Physician** Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-trar Due to (or as a consequence of). requires that the death certificate be Physician/Medical the as IF FEMALE use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy φ in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) P.0. 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, Completed by page 2 should 24a. Was an 1□ Yes 2⊠ No Physiclan; 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 or Attending 5 Pending investigation Injury 1 🔀 Natural 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident within 24 hours after death

To the Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number wx1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

6:30 AM 2008 4c. County of Death Cecil 9. Birthplace (State or Foreign MARYLAND 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. African American 16b. Kind of Business/Industry U.S. Militare N.C. 27613 20c. Location - City or Town, State APRIL 04,2008 Owings Mills, MARYland Approximate Interval Between Onset and Death UNKNOWN 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year)

3. Time of Death

Year

State Registrar Shandelya

31. Date filed (Month, Day, Year) APR 0 1 2008

Duresh

Healthcare

Maryland

VA

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** Diane M. Malloy /Medical 4c. County of Death Facility Name (If not institution, give street and number **Examiner** 8. Date of Birth Month, Day, Year June 6, 1955 5. Social Security Number **Funeral** Hours 1 □ M 2 □ 52 218-62-3175 Director Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County show a or 28a-f show t be notified at Baltimore MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 507 Brune Street 21201 permit. Pages 1 and 2 should be filed within 72 hours after death wi Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must b Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes **20** No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black ģ 3 N Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) dietary Ellicott City Nursing Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Raymond Shelton Ethel Mae Hopkins ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Tanika Malloy / Daughter 3003 F Cherrylane Road; Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 04/01/2008 Mount Zion Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home, P.A. 21. Signature of Funeral Service Livensee 638 N. Gilmor Street; Baltimore, Maryland 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician SEPTIC SHOC /Medical Due to (or as a consequence of) Examiner ND STAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit Due to (or as a consequence of): Box 68760. attending physician death certificate be Physician/Medical for use as the IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24a. Was an autopsy performed? page 2: 25. Was case referred to edical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Mo Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after dearh. To the Funeral Director. / 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide To the Hospitallor A within 24 hours after To the Funeral Direction 29a. Certifier 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RESOOD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HANTH WISSEM, 5661 LOCI- KAVEN

MORF

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Year

2008

USA

Month

Black, White, etc.

7:14 PM

Birthplace (State or Foreign Country)

MD

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

4 Unknown

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

1 X Yes 2 □ No

Registrar

State

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

MD 2+239 (GOOD SAMARITAN HOSPITAL)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3 Time of Death Year **Physician** 2001 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5. Social Security Number 9 Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🙀 F 2) 741 3435 Usual Residence of Decedent 3 Maryland Aug 4, 1941 66 Director 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a. State 10b. County 23a or 28a-f show 10 Yes 2 No the Medical Examiner must be notified Director N/A 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21217 Funeral permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "naturat", or items 23s any Injury or other traumatic event, the Medical Examiner must 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) **Private Homes** Elementary/Secondary (0-12) College (1-4or 5+) Housekeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leroy Batty Sr. Annie Mae Allen ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 16 Sunrise Court Randalistown, Maryland 21133 JoAnn White 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 DeBurial 2 □ Cremation 3 □ Removal from State Baltimore Md. 04/01/08 4 □ Donation 5 □ Other (Specify) Woodlawn Cemetery & Chapel 21. Signature of Funeral Service License 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Path: Enter the disease, of complications that caused the death. shock, othean failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Due: (If as a consequence of the condition of the c Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** /Medical a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760. physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown After this certificate has been signed by funeral director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2□ No 2 DK 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident the within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

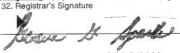
dwoo 15

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

APR 0 1 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



ORIGINAL

t or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and Division of Vital Records, completely filled in by the funeral director, the Hospital within 24 hours a

To the Funeral I

9 Unknown	9 🗆 Unknown				
art II. Other significant conditions	contributing to death but not resu	ulting in the underlying caus	se given in Part I.		use contribute to the cause of death? No 3 Probably 4 Unknown
				24a. Was an autopsy performed? 1 □ Yes 2 IA No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical			26. Place of Dear	th (Check only one)	
examiner? 1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatient 3 ☐ DOA	Other: 4 Nursing H	ome 5 🕅 Residence	6 ☐ Other (Specify)
7. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	(Month, Day, Year) on	28b. Time of Injury M	Injury at Work? 1 □Yes 2 □No	28d. Describe how injur	y occurred
3 ☐ Suicide 6 ☐ Could not lead to determine determined			fice	28f. Location (Street an City or Town, State	nd Number or Rural Route Number,

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D0025773

3. Time of Deatl

MD

USA

WHITE

FORSYTHE

Approximate Interval Between Onset and Death

Year

Day

10d. Inside City Limits

1 Tyes 2 No

3:15P м

State Registrar

Be

Certification: To

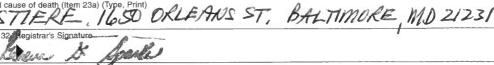
Medical

29a. Certifier

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

and manner stated



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician March 26, 2008 Virgil Raymond Norris 9:30A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1724 Selma Avenue Halethorpe Baltimore If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 233-16-9187 1**X** M 2□ F 87 West Virginia Director Mar. 11, 1921 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants: If item 27 is marked other than "natural", or items 23a or 28a-f show any Inlyor or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 ☐ Yes 2 No Director Halethorpe 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1724 Selma Avenue 21227 United States Completed by Funeral 12. Was Decedent Ever in U.S.
Armed Forces?

1 Yes 2 No 19
If Yes, Give
Year or Dates: 19 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1942 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify White 1946 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Meat Cutter Grocery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Franklin Norris Hazel Custer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffrey Norris - Son 3 Shepherd House Court, Catonsville, MD 21228 20b. Place of Disposition (Name of Meadowridge Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State 5 ☐ Other (Specify) Memorial Park 3-31-2008 | Elkridge, MD Signalure of Funeral Service Dica 22. Name and Address of Facility Ambrose Funeral Home, Inc. A My 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final 76977 ALPODOLUDOUS **Physician** disease or condition resulting in death) /Medical Due to or as a consequence of): 134889461 Examiner Sequentiary het conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the bunal-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. ATTIA Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 2 No 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director. After this certified funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manuer of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: **₩** Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide 29a. Certifier 🗓 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical E xaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Registrar

29b. Signature and title of cedifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR Arthur Harrow 7/4/

29c. License number

security Blvd Balt, Md 21244

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) Year Physician 2008 Charles Oakley Sr. 24, March 1:25A /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner FutureCare North Point Eastpoint Baltimore Co. If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 🔀 M 2 □ F 188-12-9631 Director 07-11-1923 Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Edgemere MD ... r 28a-f sh notified 1 □Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ns 23a or 2 must be n 21219 United States 2810 Willow Avenue Funeral ral", or items 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2√2√No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 7 Is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Blacksmith Farrier 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Genevieve M. Smith Grant P. Oakley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health a 2810 Willow Avenue Edgemere Maryland 21219 Lee Oaklev Item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If II any Injury or c Holly Hill Cemetery 03-27-2008 Middle River MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityDuda-Ruck Funeral Home of Dundalk Inc. 7922 Wise Avenue Dundalk MD 21222 under 23a. PM11. Enter the disease, or condications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician**

/Medical Examiner

burial-transit

use

for

ed by the a signed b

page 2 certificate

this

physician

Physician/Medical Examiner

Be Completed by

Certification: To

Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

THEROSCIEROTOC CHROIOVASCULAR Due to (or as a consequence of) NGINA LEREBROVASCULAI? RKINSONS

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 4□Pregnant at time of death

3 Ectopic pregnancy 5 ☐ Other (specify)

Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes	2□ No	3 ☐ Pro	bably	4 Donknown
24a. Was an autopsy performed 1∐ Yes 2 1	?/	Were auto prior to co death? 1 ☐ Yes	opsy find ompletion	dings available of cause of

23d. Date of delivery

23e. Did tobacco use contribute to the cause of death?

25. Was case referred to medical examiner? 1 ☐ Yes 2 100

1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

26. Place of Death (Check only one)

27. Manner of Death Natural 2 Accident

3 Suicide

4 Homicide

5 Pending investigation 6 Could not be determined

APR 0 1 2008

Injury 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 🗌 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

| 🖺 🕊 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

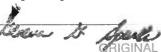
29c. License number

29d. Date signed (Month, Day, Year)
27/88 3/24/08
Place Dundak ND 2/222

31. Date filed (Month, Day, State

32. Registrar's Signature

Registrar



DHMH 17 Rev 1/2001

P.O. Box 68760,

The law requires that the death certificate be executed Division or Vital Records,

Hospital or Attending Physician: funeral After 1 24 hours after deatl filled in by

within 2

the

1 - For State Registrar

			1. Decedent's Name (First, Middle, Last)				14.7			2. Date of Dea Month	ath Day	Year	3. Time of Death
	Physici /Medi		FORTUNEE		0Z	IEL		MARCH	29	2008	07:55 PM			
	Examir		4a. Facility Name (If not institution, give	A .			_	_	r Location o		ممل	4c. C	ounty of Death N/F	
			Sinai Hospital o		ge (In yrs. la	et hirthday)	Da If Under		More	24 Hrs.	8. Date of Birt	h	·	lace (State or Foreign
	Funeral Director			M 20 X F	73	Yrs.	Months		Hours	Min.	03/14/	1935	Cour	GYPT
			Usual Residence of Decedent											
	ylanc		10a. State 10b. County			Town or Lo							1	0d. Inside City Limits 1 1 Yes 2 □ No
	88-1 e	cto	MD N/A		BA	ALTIMO	ORE							-
	ith th	Director	10e. Street and Number				10f. Zip	Code		_		10g. Citize	en of What Cour	
	ath v	ra l	7121 PARK HEIGH	S AVENUE			Was Dass	dant of L	2121		nife Vas or No	. 14	USA 4. Race - Americ	
_	ter de Item	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces	?	i		V	an, Mexicar	n, Puerto I	ecify Yes or No- Rican, etc.)		Black, White,	etc.
2	hours after death with the Maryland tural', or Iteme 23a or 28a-f show al Examiner must be notified at	ρ	3 ☐ Widowed 4 🂢 Divorced	If Yes, Give Year or Dates:			1 🗆 Yes	2 ∆ No	Specify:			S	Specify:	WHITE
9500-91212	be filed within 72 hours after death with the Marylar lal Hygiene. Id other than "natural", or Iteme 23s or 28s-f show other than "natural", or Iteme 23s or 28s-f show event, the Modical Examiner must be notified at	Completed	15. Decedent's Edi (Specify only highest grad			16a. Dece	dent's Usua kind of wo	al Occup	ation during mos	t of workii	ng	16b. Kind	of Business/In	dustry
7	within 72 ene. then "ne: he Mcdic	npie	Elementary/Secondary (0-12)	Cottege (1-4or	5+)	life.	DO NOT u	se retired OMEM	1)				OMV	HOME
	filed w Hygier Sther th		17. Father's Name (First, Middle, Last)				110	OPILIT		ar's Name	(First, Middle,	Maiden S		TIONE
anc		Be	DAVID			HAYI	AV			CHEL	,		UNOBTAI	NABLE
Maryland	d 2 should the and Ment to and Ment to marked traumatical	၉	19a. Informant's Name/Relationship (T)	rpe, Print)				(Street	and Numbi	er or Rura	l Route Numbe	er, City or	Town, State, Zip	Code)
	nd 2 lith a 27 le		GAMLIEL OZIEL	/ SON		52 (COUNT	RY D	RIVE,	PLA	INSVIEW	, NY	11803	3
ē,	一主意表		20a. Method of Disposition		رم ا	nce of Disponentery, cre	osition (Nar matory or o	ne of other plac	ce)	D	ate	20c. Loca	ation - City or To	own, State
Ē	Pages nent of ent: If It ary or o	!	1		° SHÆ	AREI	TFIL(OH C	ONG.	03/30	0/2008	BAL	TIMORE,	MD
Baltimore,	permit. Pages Department of Importent: If II eny Injury or one.		21. Signature of Funeral Service Licens	ee/). /	/		2. Name ar						BROS.	
_	207.9		100 7										SVILLE,	MD 21208
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	ne cause on each	ed the death. tine.	Do not en	ter the mod	te of dyin	ig, such as	cardiac o	or respiratory ar	rest,		Approximate Intervat Between Onset and Death
1	Physician		tmmediate Cause (Final disease or condition resulting in death)	Resp	s a conseque	ory	arre	est						2 hours
	/Medical Examiner		Todalarig in Godely	/ 1									1	3 days
		e.	Sequentially list conditions, if any, leading to inimediate	b. Due to (or a	sepso	ence of).							•	20495
	ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events											
Ď	sicien and		resulting in death) Last	Due to (or a	s a conseque	ence of):								
9/9	ate be nysici he bu	Cai		d										
90x 68760	eath certificate be executed attending physicien and for use as the burial-transit	an/Medicai	IF FEMALE:	20 - Muse sutces										
ô	attend for us		23b. Was decedent pregnant in the past 12 months?	23c. tf yes, outcom 1 Live birth	2 Fetal	death 3[Ectopic p		/			23	3d. Date of delive Month	ery Day Year
o.	he de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	at time or dea	aun J	Other (sp	Jecny) _						
٦.	The law requires that the de ate has been signed by the a page 2 should be detached f	by Physic	Part It. Other significant conditions co	ntributing to death	but not resul	ting in the u	underlying o	ause giv	en in Part I	l.	23e. Did to	obacco us	e contribute to t	he cause of death?
S	quires n sign ald be		Right tota	l Knee	arth	ropl	asta	2			1 🗆 🕆	Yes 2. ☑	No 3□ Prol	pably 4 □Unknown
<u></u> ပွ	aw require s been sig 2 should b	Completed	Right tota Atrial fibr	illa tion	2		-				24a. Was		24b. Were auto	opsy findings available
ž	The la	E									perfo	rmed3	death? 1 ☐ Yes	mptetion of cause of
Vital Records,	nysicien: The law his certificate has I director, page 2 s	Bec	25. Was case referred to medical examiner?							e of Death	Check only o	ne)		
	Physic this ce	P	1 ☐ Yes 2 ☑ No	-	tient 2 E				4 🗆 N	-			Other (Special	fy)
Ē	ding P h. After t funera	i io	27. Manger of Death 1 ☑Natural 5 ☐ Pending	28a. Date of the (Month, D	jury la <i>y Year)</i>	28b. Time o tnjury		28c. Injur Wor	yat k? Yes 2.⊡		28d. Describe l	how injury	occurred	
<u>s</u>	ttend death stor: /	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of tr	niunz - At hon	no farm et	M factor		Tes 2		28f Location /	Street and	Number or Run	al Route Number,
Division of	after after Direction by	Certification;	4 Homicide determined		etc. (Specify)		ieer, iactor	y, onice			City or To	wn, State)		
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying Phy	sicien: To the bes	t of my know	rledge, deal	th occurred	at the tir	ne, date ar	nd place,	and due to the	cause(s) a	and manner as	stated.
	n 24 h	Medicai	(Check only 2 Medical Exam one)	ner: On the basis and manner s		on and/or in	rvestigation	n, in my d	pinion, dea	ath occurr	ed at the time,	date and p	place, and due t	o the cause(s)
	To the I	ž	29b. Signature and title of certifier						e number				signed (Month,	
			Mashio	uis M	D.		K	ES.	-00	0		Mari	ch 29,	2008
	n		30. Name and address of person who c					. 0	***					
			Markos Kashiou		nal Hotrar's Signatu		r of R	acti	more	•				
	Sta Regist		•				6 -	_						
DH	MH 17 Rev 1/2	-	APR 0 1 2	IUX Sem	ALL A	A P	mark!	P		-			AL - 100	
						ORIG	INAL							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 2 0 0 8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day March 25, 2008 **Physician** Helen Irene Pinkett 8:40 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Marvland General Hospital Baltimore City If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 8. Date of Birth (Month, Day, Year) 07/04/1960 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2XXF MD Director 47 220-80-5321 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits show ral", or items 23a or 28a-f shov Examiner must be notified at Baltimore City MD 1X Yes 2 □ No Director 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 534 N. Carrollton Ave., APT 3 21223 HSA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give 1981 — Year or Dates: XXNever Married 2 Married 1 ☐ Yes 2 🛛 No Specify: Black Specify: þ 3 Widowed 4 Divorced 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Soldier the US Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arvilla Yancey Vernon Pinkett 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2417 Dorton Ct., Baltimore, MD 21230 19a. Informant's Name/Relationship (Type. Print) S Gregory E. Butler / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition :04/01^D/2008 Important; If it any injury or c once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Owings Mills, MD Garrison Forest Vet.Cem 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility} Rendon-Bailey Funeral Home, PA 2818 E. Baltimore St., Baltimore, MD 21224 21. Signature of Funeral Service Licenses N 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Hyperkalemia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated as or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed ending physician and use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year signed by the at d be detached for 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an 2 ∏ No To the Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 XYes 2 No 1X Inpatient 2 ER/Outpatient 3 DOA Certification: To After this Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29b. Signature and fitle of certifier 29d, Date signed (Month, Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 40 MIR Registrar's Signature 31. Date filed (M State Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

I Records, P.O. Box 68760,	requires that the death certificate be executed
Reco	The law re
Division or Vital	Hospital or Attending Physician: 7
	B Hos

		1- State of State of Registrar	Maryland	d / Department of Certificate of				0000	1010
ų		Registrar 1. Decedent's Name (First, Middle, Last)		Certificate	oi Deal	2. Date of D	Reg. No.	2008	3. Time of Death
Physicia /Medic		Agnes C.		Prichard		Month 3	25	2008	124 PM
Examin		4a. Facility Name (If not institution, give street and num	ber)	4b. City, Tov				County of Death	
		FRANKLIN SQUELVE HOSPI 5. Social Security Number 6. Sex	TAL Ce	enter Ros	seda	der 24 Hrs. 8. Date of B		3aLTIV	
Funeral Director		217–20–8693 ¹□м ²\XF	. Age (III yrs. Ia.	Months D	ays Hour		ay, Year) 13,	1924 Mar	place (State or Foreign intry) yland
ow ot		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location					10d. Inside City Limits
a-f sh tified	ctor	Maryland Baltimore		Dundalk					1 □Yes 2 No
or 28	Director	10e. Street and Number		10f. Zip Co			"	izen of What Cou	ntry?
ns 23a must	Funeral	1949 Walnut Avenue 11. Marital Status 12. Was December 13. Was December 14. Was December 15. Was December 1	lent Ever in U.S.		1222 t of Hispanic	Origin? (Specify Yes or N	L	USA 14. Race - Ameri	can Indian,
permit. Fages I and a should be filled within 7.2 frouts after dearth with the Marylan permit. Fages I and a should be filled within 1.2 frouts after dearth with the filled permit of the filled marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	ğ	Armed For 1 □ Never Married 2 □ Married 1 □ Yes 3 ※ Widowed 4 □ Divorced Year or Da	2 📉 No	If Yes, specify 1 ☐ Yes 2 🛣		Origin? (Specify Yes or Nican, Puerto Rican, etc.)		Black, White	etc. nite
"natu	Completed	15. Decedent's Education (Specify only highest grade completed)	Į.	16a. Decedent's Usual O (Give kind of work d life. DO NOT use re	ccupation lone during n	most of working	16b. Ki	ind of Business/Ir	ndustry
than the Mc	dmo	Elementary/Secondary (0-12) College (1-12 years	4or 5+)	Office Worl			Ret	hlehem S	Steel
other vent, t	Be C	17. Father's Name (First, Middle, Last)		OTTICE WOL		other's Name (First, Middi			70001
Menta arked atic ev	To E	Harry Farber			The	eresa Murphy			
and 2 snd ealth and n 27 is m		19a. Informant's Name/Relationship (Type. Print) Paula J. Betz Friel		35707 Clam 8	Shell	mber or Rural Route Num Circle, Sell			· · · · · · · · · · · · · · · · · · ·
it of H.		20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Removal from S		ace of Disposition (Name of metery, crematory or other		March 29,	1	ocation - City or T	
artmer artmer ortant: Injury	1.4	4 □ Donation 5 □ Other (Specify) 21. Signalure of Funeral Service Licensee	Gard	dens of Faitl				dale, Ma	aryranu
any l	a d	Chithony (on	NO VI	Connectly 7110 Sol.	Funer lers F	al Home Of Doint Road, D	Dunda Dunda	IK,P.A. lk,MD. 2	21222
100		23a. Part1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea	used the death.						Approximate Interval Between
hysician	ř	Immediate Cause (Final disease or condition		rdial In	face	tron			Onset and Death
/Medical Examiner			r as a conseque	ence of):		Disease			
\$ # # # # # # # # # # # # # # # # # # #	e	if any, leading to immediate bue to (c	r as a conseque	ence of):	Lry	Di sea se		- 27	
nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
physician and the burial-transit		resulting in death) Last Due to (c	r as a conseque	ance of):					
physics the l	edica	d							
attending p	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outc	ome pf pregnan		nancy			23d. Date of deliv	•
the att	sicis		nt at time of dea					Month	Day Year
ed by detacl	Phy	Part II. Other significant conditions contributing to de	ith but not result	ting in the underlying caus	e given in Pa	art I. 23e. Did	tobacco u	use contribute to	the cause of death?
n sign ald be	d by					1	Yes 2	□No 3□Pro	bably 4 Nnknown
as bee 2 sho	Completed					24a. Wa	s an opsy	24b. Were aut	opsy findings available
ate ha	Som					per 1∐ Yes	formed?	death?	2 □ No
certific ector,	Be	25. Was case referred to medical examiner? 1 Hospital: Hospital:			Other:	lace of Death (Check only			
r this	-: To	27. Manner of Death 28a. Date of	Injury 2	R/Outpatient 3 DOA 28b. Time of 28c.	Injury at Work?	Nursing Home 5 Re			ify)
ath. r: Afte e fune	ation	1 Avatural 5 Pending (Month 2 Accident investigation	, Day Year)	Injury M	Work? 1 ☐ Yes 2				
after des Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place buildin	of injury - At hom g, etc. <i>(Specify)</i>	ne, farm, street, factory, of	fice	28f. Location City or T	(Street an own, State	nd Number or Rui e)	ral Route Number,
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the after completely filled in by the funeral director, page 2 should be detached for	Medical C	29a. Certifier (Check only one)	sis of examination	rledge, death occurred at the on and/or investigation, in	he time, date my opinion,	e and place, and due to the death occurred at the time	e cause(s e, date an) and manner as d place, and due	stated. to the cause(s)
o de de de de de de de de de de de de de	Me	29b. Signature and title of certifier			cense numb		29d. Da	te signed (Month	, Day, Year)
6		> Chulcs 2	Do, 1	UD D	006	1907	3	260	8
10		30. Name and address of person who completed cause	,	23a) (Type, Print) FRANKLIN	<	are DR	0-1	To mo	21237
Sta			gistr <i>a</i> r's Signatu	ure	ال ال	CT C IVIN	Bal	TO MO	1 010 3 /
Registr	ar	APR 0 1 2008	eur l	Sports.					
H 17 Rev 1/20	001								
				ORIGINAL					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

				State of Ma							•		egible.	
			1 - For State Registrar					te of L				eg. No	008	10438
	Physici	an	1. Decedent's Name (First, Middle, Las	•							2. Date of Dea Month		Year	3. Time of Death
	/Medic		Dorothy K.	Power:	S			_			March	31	2008	10:15 A M
	Examin	er	4a. Facility Name (If not institution, give Sunbridge Nursin				4b. City		Location of			4c. C	ounty of Death Ceci	
The state of	Funeral	4/6	5. Social Security Number 6. Se		e (In yrs.	. last birthday)		er 1 Year	If Under 2	4 Hrs.	8. Date of Birth			place (State or Foreign intry)
To the	Director		139-16-1232	□M 2⊠F	8	7 Yrs.	Months	Days	Hours	Min.	July 19	192	20	PA PA
	ehow	'n	10a, State 10b, County		10c. Ci	ity, Town or Lo	cation		F 3.1 .					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th the N or 28e-f	Director	Maryland Cecil 10e. Street and Number				10f. Z	ip Code	Elkto	on	1	0g. Citize	n of What Cou	
	ath wi		1 Price Road						21921				USA	
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28e-1 ehow or other traumatic event, the Madical Examinar must be notified at	by Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 XYes 2 1 If Yes, Give Year or Dates:	۷o 19	13_	Was Dece If Yes, sp 1 Yes		spanic Origi n, Mexican, Specity:	in? (Spec Puerto F	ofy Yes or No- lican, etc.)		Race - Amer Black, White pecify:	
Ö	2 hou	ted	15. Decedent's Ed (Specify only highest grad	ucation	. 13	16a. Dece	dent's Us	ual Occupa	tion	of working		16b. Kind	of Business/I	ndustry
121	within 7 iene. then "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)			use retired) (e Dec	uring most o	OI WOIKIII	9		11igend Navy	ce Dept.
Maryland 21215-0036	buld be filed Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, Last) James J. Powe	rs							(First, Middle, A .	Maiden Si		
Mary	d 2 should th and Mer 7 is marke traumatic		19a. Informant's Name/Relationship (7 Virginia Weber	ype, Print)			-				Route Number	-		
<u>ē</u>	s 1 and 2 f Health Item 27 other tra		20a. Method of Disposition		20b.	Place of Dispo cemetery, crer	sition (Na	other place		pril	uakerto	OWII. 20c. Loca	tion - City or T	own, State
<u>E</u>	Page nent o ant: H ary or		1 ⊠ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			rgan Ce			" ; A;	200	8 (Cinna	minson	, New Jersey
Baltimore,	permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other anges.		21. Signature of Funeral Service Licen:	Hallen	0	<i>(</i>)	3	111 M	s of Facility Ounta	in R	oad. Pa	sader	eral Ho na, MD	me, P.A. 21122
73			23a. Part1. Enter the disease, or components of the components of	olications that caused one cause on each lin	the dear	_					respiratory arr	est,		Approximate Interval Between Onset and Death
14	Physician /Medical		disease or condition resulting in death)	a. CARI Due to (or as	a consec	PULT quence of):	10~ A	R	Arre	8				DAy
	Examiner	er	Sequentially list conditions, if any, leading to immediate	b. Chr.		Ruence of):	cl	gns.	bline	my	<u>-</u>			
B	rcuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c. COP	-/									
3760,	ate be executed nysician and he burial-transit	cai Ex	resulting in death) Last	Due to (or as a consequence of):										
39	tificate ig phys as the			d										
P.O. Box	To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physical physical physical physical filed in by the funeral director, page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Feta	aldeath 3□	Ectopic Other (s	pregnancy specify)				23	d. Date of deliv Month	v ery Day Year
	es that the igned by be detact		Part II. Other significant conditions co	ontributing to death b	ut not res	sulting in the u	nderlying	cause give	n in Part I.				,	the cause of death?
Records,	w requi	leted									1 □ Y			onsy findings available
E Re	The lav	Completed					-				autops	med?	prior to death? 1 ☐ Yes	opsy findings available ompletion of cause of 2 No
Vital	ician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe			Check only or	77		
Division of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical cumpletely filled in by the funeral director.	tion: To	1 Yes 2 No 27. Manner of Death Notural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	rv	28b. Time of Injury		28c. Injury Work	at Nurs	2	e 5 Reside 8d. Describe h			rfy)
Divis	after dea after dea Director	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inj building, et	ury - At h c. (Speci	iome, farm, str	eet, facto	ry, office		2	8f. Location (S. City or Town		Number or Ru	ral Route Number,
	Mospite 24 hours Funeral etely filler	Medicai C	29a. Certifier (Check only one) 1X Certifying Ph. 2 Medical Exam	rician: To the hest iner: On the basis of and manner sta	f examina	owledge deall ation and/or in	t occurra vestigatio	dat the tim n, in my op	e date and inion, death	placa, a	nd ous to the c d at the time, d	ausu(s) at ate and p	nd hidmoor as lace, and due	stated to the cause(s)
	To the To the Calmple	Me	29b. Signature and title of certifier	. 17			25	9c. License			2		signed (Month	
	ai		> P.V. Nanger					D00	6573	3		Ċ.	3/31/20	08
	4		30. Name and address of person who c	completed cause of d	eath (Ite	m 23a) (Type,	Print)	S	oun h	e d	e Nu	(5)	e Ham.	e
	Sta Registr	_	31. Date filed (Month, Day, Year) APR 0 1 200	32 Registr	ar's Sign		a Bl					371)	
150	Registr	ar	APR U T ZUI	18 19 200		H A.	. 100							

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 Month **Physician** George Howard Phillips 29 16:00 March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Bel Air Upper Chesapeake Medical Center Harfard County If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, Year 15 Birthplace (State or Foreign Country) **Funeral** 1 M 2 ☐ F 217-20-3408 92 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits iral", or Items 23a or 28a-f show Examiner must be notified at Maryland Harford County Forest Hill 1 ☐ Yes 2X No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21050 United States 2406 Putnam Road Completed by Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygene. Important: If Item 27 is marked other than "natural", or lie any Injury or other traumatte event, the Medical Examine 1XXes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🛣 No Specify. 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) John K. Ruff 11 N/AConstruction Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Barclay Phillips Mary Zora Poteet 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Steve Phillips (Son) 2128 Poteet Road, Forest Hill, Maryland 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Wipurial 2 ☐ Cremation 3 ☐ Removal from State Highview Memorial Gardens | April 2,2008 Fallston, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services - Bel Air
3 Newport Drive, Forest Hill, Maryland 21050 21. Signature of Funeral Service Licenses 1er 23a. Part1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Du to (or as) consequence of): **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown $9\,\square\, Unknown$ significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 res 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Yes 2 | No 2 ER/Outpatient 3 DOA Certification: To 1 Impatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Matural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifie

State

Maryland 21215-0036

Baltimore,

68760

Ö

Records,

Division or Vital repro

99

purva Registrar

31. Date filed (Month, Day, Year) APR 0 1 2008

30. Name and drest of person who completed cause of death (Item/ 3a) (Type, Print)

Registrar's Signature ----

Bel AIRMD 21014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008 Year Month **Physician** 28,8:30 P M Esther M. Peeples March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec 31, 1930 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 1 □ M 2 💢 F Mary Land 218-26-7330 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Maryland Harford White Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4970 Jolly Acres Road 21161 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specity: White 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If Item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Newton Strong Dorothy Theodore 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Peeples, Son 62 Enola Drive Stewartstown, PA 17363 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 04/02/08 4 ☐ Donation 5 ☐ Other (Specify) Good Shepherd Cemetery Ellicott City, MD 21. Signature of Funeral Service Licensee MacNabb Funeral Home, P.A. Thomas Gregor Frederick Road Catonsville, MD_21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** povolemic hours /Medical Due to (or as a consequence of): Examiner Res Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical advanced Stage 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Vita To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 X Inpatient မ 2 ☐ ER/Outpatient 3 ☐ DOA ō 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred lon 1 X Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours _____
To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) · Jun, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harford Road, Suite 105, Fallston, MD

State Registrar 31. Date filed (Month, Day, Year)

APR 0 1 2008

Registrar's Signature

08-02516	
Gary Lee Pregi	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Provided Formation 1	- w. , -			1-For State Certificate Certif		Reg. No	2008	3 1044	
4. Facility Name of zontrainance, purpose internal management of the common of the com	Medi				o i	Month Day	Year		
Second Search, Number Second Search, Number Second Search, Number Second Search, Number Second Search, Number Second Search, Number Second Search, Number Second Search, Number Second Search, Number Second Search, Number Second Search, Number Second Search, Number Second Search, Number Second Search, Number Second Search, Number Search Search, Number Sear				4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	1 4	c. County of Death		
214-60-1863 XM 2 F 56 Va Morthle Gay Seart Min VEB 23, 1952 Courty District Courty District Courty District Courty District Courty District Courty District Distric		Funan						place (State or Foreign	
The state of the court of the c				214-60-1863 1XM 2 F 56 Y	Months Days Hours Min	Min. Country) D1S			
2 900 O DO O DO O DO O DO O DO O DO O DO					ation		1		
2 900 O DO O DO O DO O DO O DO O DO O DO		yland -f shov	ģ						
Security Free real Research (Seption Symbol and Place an		he Mar or 282	Direc			log. G		yr	
Security Free real Research (Seption Symbol and Place an		n with to rms 23a be not	eral	11. Marital Status 12. Was Decedent Ever in U.S. 13. V	as Decedent of Hispanic Origin? (S		14. Race - America	an Indian, Black,	
Peter V. Prepi February Title Mailing Address (Street and Number of Route Route Number City of Youn, State) Code		d) + 1_		1 Yes 2 X No		rican, etc./		ito	
Peter V. Prepi February Title Mailing Address (Street and Number of Route Route Number City of Youn, State) Code		ours aft atural'	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent	ent's Usual Occupation (Give kind of				
Peter V. Prepi February Title Mailing Address (Street and Number of Route Route Number City of Youn, State) Code	ä	in 72 h han "n Jical E	plete	Elementary/Secondary (0-12) College (1-4 or 5+)			C 1 D		
Peter V. Prepi February Title Mailing Address (Street and Number of Route Route Number City of Youn, State) Code	ò	ed with hygiene other t	Com					taurant	
Linda M. Harbin, sister 6247 Yunker Street Lansing, MI 48911 200, Place of Dapastoon (Name of Cornetory) 201, Place of Dapastoon (Name of Cornetory) 2	1246		Be						
Security Security		2 shoul 2 and M 27 is m	۱						
Security Security	5	1 and F. Health		20a. Method of Disposition 20b. Place of Disp	osition (Name of cemetery,				
Physician (Medical Administration of the Complete of Section 1997) and the Complete of Section 1997 (Section 1997) and the Section 1997 (Section 1997) and the Section 1997 (Section 1997) and the Section 1997 (Section 1997) and the Section 1997 (Section 1997) and the Section 1997 (Section 1997) and the Section 1997 (Section 1997) and the Section 1997 (Section 1997) and the Section 1997 (Section 1997) and the Section 1997 (Section 1997) and the Section 1997 (Section 1997) and the Section 1997 (Section 1997) and the Section 1997 (Section 1997) and the Sec	8	Page ment o		4 Donation 5 Other Specify: Metro Cr					
Physician Medical xaminor	20	Depar Depar Impo		21. Signature of Funeral Service Licensee George MacNabb 22					
Immediate Cause (Final disease or condition resulting in death) Sequentially list condition. Sequentially list conditions. F				the mode of dying, such as cardiac	or respiratory arrest, si	hock, or heart	Approximate Interval		
Sequentially list conditions, if any, leading to immediate course. Each of the course of pregnancy and purpose of property of the course of pregnancy and purpose of property of the course of pregnancy and purpose of property of the course of pregnancy and purpose of property of the course of pregnancy and purpose of property of the course of pregnancy and purpose of property of the course of pregnancy and purpose of property of the course of pregnancy and purpose of property of the course of pregnancy and purpose of property of the course of pregnancy and purpose of property of the course of pregnancy and purpose of property of the course of pregnancy and purpose of property of the course of pregnancy and purpose of property of the course of pregnancy and purpose of property of the course of pregnancy and purpose of property of the course of pregnancy and purpose of property of the course of pregnancy and purpose of property of the course of pregnancy and purpose of property of the course of pregnancy and property of the course of pregnancy and purpose of property of the course of death? Vere 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Other significant conditions autopay in the course of pregnancy and property of the course of pregnancy and property of the course of death? Vere 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Other significant conditions autopay in the underlying cause given in Part II. Other significant conditions autopay in the underlying cause given in Part II. Other significant conditions autopay in the underlying cause given in Part II. Other significant conditions autopay in the underlying cause given in Part II. Other significant conditions autopay in the underlying cause given in Part II. Other significant conditions autopay in the underlying cause given in Part II. Other significant conditions				Immediate Cause (Final disease a. Contact Gunshot Wound of Head					
The standard of the standard			_	b					
UNPENDED AMENDED AMENDED AMENDED AMENDED AMENDED			niner	if any, leading to immediate Due to (or as a consequence of):					
The part of the		cuted and transit		events resulting in death) Last Due to (or as a consequence of):					
Accident investigation 3 Suicide 6 Could not be determined	_	e be exe sician a	edic						
Accident investigation 3 Suicide 6 Could not be determined	8789 **	ath certificate attending phy or use as the l		23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 4 Pregnant at time of death 5			•	ay Year	
Accident investigation 3 Suicide 6 Could not be determined		t the de by the ached f		Ja Olikilowii	underlying cause given in Part I.	23e. Did tobacc	o use contribute to th	ne cause of death?	
Accident investigation 3 Suicide 6 Could not be determined		ires tha signed	d by			1 Yes 2	No 3 Proba	ibly 4 🗹 Unknown	
Accident investigation 3 Suicide 6 Could not be determined	, de la comp	he law requate has been age 2 should				autopsy performed*	prior to co death?	mpletion of cause of	
Accident investigation 3 Suicide 6 Could not be determined	-	certific	Be C	examiner?	Inthor:				
Accident investigation 3 Suicide 6 Could not be determined	Ž	Physic Per this eral dire	-	1 Yes 2 No				Scene	
29a. Certifier (Check only one) 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. O.C.M.E. March 31, 2008	5	lending eath. or: Afi	tion	1 Natural 5 Pending Mar 30, 2008 0000 hrs					
A Secretary of the person who completed cause of death (Item 23a) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Death of the person who completed cause of death (Item 23a) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Death of the person who counted at the time, date and place, and due to the cause(s) and manner as stated. Death of the person who counted at the time, date and place, and due to the cause(s) and manner as stated. Death of the person who counted at the time, date and place, and due to the cause(s) and manner as stated. Death of the person who counted at the time, date and place, and due to the cause(s) and manner as stated. Death of the person who counted at the time, date and place, and due to the cause(s) and manner as stated. Death of the person who counted at the time, date and place, and due to the cause(s) and manner as stated. Death of the person who counted at the time, date and place, and due to the cause(s) and manner as stated. Death of the person who counted at the time, date and place, and due to the cause(s) and manner as stated. Death of the person who counted at the time, date and place, and due to the cause(s) and manner as stated. Death of the person who counted at the time, date and place, and due to the cause(s) and manner as stated. Death of the person who cause(s) and manner as stated. Death of the person who cause(s) and manner as stated. Death of the person who cause(s) and manner as stated. Death of the person who cause(s) and manner as stated. Death of the person who cause(s) and manner as stated. Death of the person who cause(s) and manner as stated. Death of the person who cause(s) and manner as stated. Death of the person) Diviei	ital or Att urs after de ral Direct	ertifica	3 Suicide 6 Could not be	eet, factory, office building, etc.	or Town, State)			
O.C.M.E. OCME March 31, 2008 O. Name and address of person who completed cause of death (Item 23a)	3)	he Host n 24 ho re Fune Jetely fi		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occ					
O.C.M.E. OCME March 31, 2008 O. Name and address of person who completed cause of death (ftem 23a)		To th withii To th	Medi	and manner stated.	29c License number	290			
				The Millian A	00	ME		•	
Theodore M. Ang, Jr., MD. Assistant Medical Examiner Thi Penn Street, Baltimore, MD 21201		1			111 Pope Street Baltima	ro_MD 21201			
State 31. Date file (Month, Pay Year) 008 32. Registrar's Signature		١	State	A	TI Fenn Street, Baltimol				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			1 100							All Copies		-	
			For State	State of M	laryland /					Mental Hy	/gien	enna	10442
			1 - State Registrar			Cei	rtificate	of D	Death		Reg. N	o.	10716
	Physic	ian	Decedent's Name (First, Midd	(le, Last)						2. Date of D		ay Year	3. Time of Death
	/Med		Laura	P	ustern	rak				Marc	i	41 -	
	Exami		4a. Facility Name (If not institution	n, give street and number)		4b. City, To	own, or L	Location of Dea			c. County of De	
			THE This	Hopkins	Hospitz	11	R	alt	more!	(iter-			
	Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. last t	birthday)	If Under 1	Year	If Under 24 Hrs	8. Date of Bi	rth	9. B	rthplace (State or Foreign country)
	Director		385-48-0672	1 □ M 2 🛣 F	53	Yrs.	Months	Days	Hours Min	8. Date of Bi Month, D. Nov. 28	3, real	954 M	ichigan
	p _		Usual Residence of Decedent		γ								
	show thow	_	10a. State 10b. County		10c. City, To		cation						10d. Inside City Limits
	B Ma	cto	Virginia Fair	tax	Reston	l							1 ☐ Yes 2 ₹₹No
	th th or 28	ire	10e. Street and Number				10f. Zip C	ode			10g. C	itizen of What C	Country?
	th wi	ai	1308 Stamford	Way			2019	94			U.S	.A.	
	deal	ner	11. Marital Status	12. Was Decedent	Ever in U.S.	13. \	Vas Decede	nt of His	panic Origin? (8	Specify Yes or Norto Rican, etc.)		14. Race - Am	
9	after or Ite	Ē	1 ☐ Never Married 2X Mar	Armed Forces ned 1 ☐ Yes 2 🔀		- 1				to Rican, etc.)		Black, Wh	
03	ours :	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			Yes 2	XI No	Specify:			Specify: W	hite
21215-0036	72 hours after death with the Maryland naturel', or Items 23a or 28a-f show of all Examitred outsides at	Completed by Funeral Director	15. Deceder	nt's Education	16	a. Deced	lent's Usual	Occupat	ion		16b. h	Kind of Busines:	s/Industry
21	within 7 ene. then "r	ple	Elementary/Secondary (0-12)	st grade completed) College (1-4or	5+)	life. L	NOT use	done du retired)	ring most of wo	nking			
2	filed within Hygiene. Sther then sent, Inc. Men.	100		5+		Phys	ician				Med	ical Se	rvices
	e filed Il Hygi other vent, Il	Be (17. Father's Name (First, Middle,	Last)				1	18. Mother's Na	me (First, Middle	, Maide	n Sumame)	
a	ould be Mental arked o	To	Michael Paster	nak					Anna B	ufka			
Maryland	2 should and Menis marke	_	19a. Informant's Name/Relations	ship (Type, Print)	19	b. Mailin	g Address (S	Street an	d Number or R	ural Route Numb	er, City	or Town, State.	Zip Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Items 23a or 28a-f show any injury or other freumatic event, the Medical Examinational by notified at 2008.		Jonathan Sokol	ow/Husband						ston, Va			, ,
Baltimore,	of Health Item 27 i		20a. Method of Disposition		20b. Place	of Dispos	sition (Name	of		Date	20c. L	ocation - City o	r Town, State
20	Pages nent of I		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	3 □Removal from State			ing Ci			/31/09			
∄	permit. Pag Department Importent: I any injury o		21. Senature of Funeral Service		Se		es . Name and		tion 03	/ 31/00	Ch		, Virginia
Ba	permit. Departr Importa		11/	MOO MOO	968						_		. Maple Ave.
			23a Part 1 Enter the diseases of	Mass		Mo	ney &	Kin	g Funer	al Home,	, In	c.Vienn	a, Va. 22180
			23a. Part 1. Enter the disease, or shock, or heart failure. List	only one cause on each I	ine.	not ente	a me mode c	or dying,	such as cardia	c or respiratory a	irrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a6	ram	neg	afive	b	actere	ma			6 nurs
	/Medical Examiner		Tooling III dodn'y	Due to (or as	a consequence	e of):		·	C				
L		L	Sequentially list conditions,	b	Linary		ract	15	Hechon				days
	pe sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequente	e of):							· ·
	and tran	can	that initiated events resulting in death) Last	c									
50,	be executed sician and burial-transit	Ê	The state of the s	Due to (or as	a consequence	e of):							
8760,	hy he	dical		d									
, Q	leath certific attending pl	Physician/Med	IF FEMALE:										
Box	ttend trend	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	of pregnancy 2 Petal deat	h 3 🗆	Ectopic preg	nancv				23d. Date of de	,
<u>.</u>	at the de by the a tached f	sic	1 ☐ Yes 2 ☒No 9 ☐ Unknown	4☐ Pregnant a	t time of death	5 🗆	Other (speci	ify)				Month	Day Year
P.0	d by etacl	Phy											
Ś	igned be deta	by	Part II. Other significant condition	ons contributing to death b			derlying caus	se given	in Part I.	23e. Did t	obacco	use contribute to	o the cause of death?
ord	w requir been si should	ted	1º resussic	Dreast Car	SINOWE	<u>w</u>	ith the	toke	108	1 🗆 '	Yes 2	DXNo 3 □ P	robably 4 Unknown
Vital Records,	law las be	ompleted	brain an	d liver m	ir tasta	218	rece	nta	1	24a. Was		24b. Were a	utopsy findings available
m.	The lav	ю	aiven ch	ematheran	1	-	,		0	autor perfo	ormed? 2 No	death?	completion of cause of
ita	icien: Th certificate rector, pag	Bec	25. Was case referred to medical	erro raci apo				2	26. Place of Dea	ath (Check only o	-	1 1016	2 2 140
>	d 5	2	examiner? 1 ☐ Yes 2 XNo	Hospital:	ent 2 ER/O	utpatient	3□ DOA	Other:		lome 5 ☐ Resid		6 □Other /Spe	icify)
Division of	ig Ph ter thi		27. Manner of Death	28a. Date of Inju	ry 28b.	Time of	28c.	Injury a		28d. Describe			
<u>0</u>	uttendin death. ctor: Af y the fur	atlo	1 Natural 5 ☐ Pendin 2 ☐ Accident investig	9	y reary	Injury	М	Work? 1 ☐ Ye	s 2 No				
<u>Vis</u>	or Attend after death Director: /	ific	3 ☐ Suicide 6 ☐ Could a 4 ☐ Homicide determ	ined 289. Place of Inj	ury - At home, fa	arm, stre	et, factory, o	ffice		28f. Location (Street ar	nd Number or R	ural Route Number,
Ö	Hospitel or Attending 14 hours after death. Funerel Director: After tely filled in by the fune	Certification:	4 I Homoloo	building, et	с. (Specify)					City or Tov	vn, State	9)	
	bour hour inere ly fille		29a. Certifier 1 Certifyin	g Physician: To the best	of my knowledg	e, death	occurred at t	he time,	date and place	, and due to the	cause(s	and manner as	s stated.
	he Hi n 24 n 24 he Fi	edical	(Check only 2 Medical one)	Examiner: On the basis of and manner sta	examination at	nd/or inve	estigation, in	my opin	ion, death occu	rred at the time,	date and	d place, and due	to the cause(s)
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	ž	29b. Signature and title of certifier				29c. L	icense n	umber		29d. Da	te signed (Mont	h, Day, Year)
•			1	1 NK	D			P20	0624		11	ah 74	2000
	3		30. Name and address of person	who completed cause of d	eath (Item 23a)	(Type, P	rint)	, ,	-3/		Ma	101 67	2000
)		Zeshan K	Paroust 1	600 A	Join	hlahl	F. C	troot	R. Himi	no -	MARIL	land 71787
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	lo	1 40	ر ا	HEE!	CI PULLIFICE	· U)	7	10000000
	Registr	ar	APR 0	I ZUUD JE	euse D	X A	DRALL	,				•	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** POPE 9:40 AM MERCEDES 2008 ARCH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BACTIMORE NORTHWEST RANDAUS TOWN HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month), Day, 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Year) 1 M 2 F Months Days Hours 020-24-4 Director 02 Massachusetts Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2/∑/No Director Maryland Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States of America 21117 9400 Wordsworth Way # 404 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Given Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes X ☐ No Specify. Specify: White Completed by 3√√Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Home Maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Evsebe Rebeuo ٩ Mercedes Amara1 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert W. Pope (Son) 9400 Wordsworth Way, # 404, Owings Mills, MD, 21117 20c. Location - City or Town, State 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition XXBurial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cemetery 04/02/08 Pikesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 21. Signature of Funeral Service 8728 Liberty Road, Randallstown, Maryland 21133 23a. Par1. Enter the disease shock, or heart failure. I , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MYOCARDIAL INFARCTION HLVTE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ate has been sign page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Physician: The certificate 1∐ Yes 2 - No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital: 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. hours after death. 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 24 hours a Euneral I 1 🖵 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only

State Registrar

To the I

29b. Signature and title of certific

29c. License numbe

D57722

1838 GREENE TREE ROAP #300 PIKESVILLE

29d. Date signed (Month, Day, Year)

2008

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RICHARDSON

M.D

sistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Physician 1400 Donald 28 MARCH 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hopkins BAYVIEW MEDICAL CONTRO Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1**⊠**M 2□F Director 216-30-7228 12/17/1935 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 □Yes 2 No Director Dundalk MD Baltimore 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number death \ Funeral 1932 Penhall RD. IISA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify 2 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Printer 10 Printing permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If Item 27 is marked other 1 any Injury or other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sara Cleora Hollingshead Hubert Garland Puller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joann L. Puller 1932 Penhall Rd. Dundalk, (wife) MD. 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ☐Donation 5☐Other (Specify) Sacred Heart of Jesus 04/03/2008 Dundalk, MD 22. Name and Address of Facility Duda-Ruck Funeral Home of 21. Single ure of Funeral Service Licensee 7922 Wise Ave. Dundalk, MD 21222 Dundalk, Inc. 63a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 AAJ 3 Immediate Cause (Final disease or condition resulting in death) Respirator **Physician** /Medical Due to (or as a consequence of 8 days Examiner neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Oborto (or as a consequence of) Examine requires that the death certificate be executed burial-tran and Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ed by the a detached f P.0. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 24a. Was an autopsy performed 2 □ No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? To the Hospital or Attending F within 24 hours after death.
To the Funeral Director; After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 March 29, 2008

State Registrar BALTIMORE, MP

21224

\$940 Eastern Avenue 82. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HUNT, MP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician** Andy /Medical Carey 4a. Facility Name (If not institution, give street and number) Examiner Nulsing If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗗 F Days Hours 200-94-285 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Examirer must be notified at 10c. City, Town or Location Funeral Director Imore 10e. Street and Number 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No. Specify: þ 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) marketon 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Mid Nadi ၉ Hawai 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S

29b. Signature and title of certifier

5 Pending investigation

6 Could not be

ign - Dear

determined

2 Accident

4 Homicide

3 Suicide

29a. Certifier (Check only one)

			/
			10d. Inside City Limits
			1 ☐ Yes 2 No
	10g. C	Citizen of What Co	untry?
		US	A
N	0-	14. Race - Ame Black, White	
		Specify:	BLACK
	16b.	Kind of Business/l	Industry
		m.c	· I ·
dle	, Maide	en Surname)	

Year

Birthplace (State or Foreign Country)

6,2008

4c. County of Death

2. Date of Death

Month

Maerch

8. Date of Birth (Month, Day,

Physician /Medical

Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-trar funeral director, page 2 should

Physician/Medical

þ

Completed

Be

Certification: To

Medical

Division of Vital Records, P.O. Box 68760,

1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	metro Crematous 4-1-08 Carto	ville, mD.
21. Signature of Funeral Service Lice	Cenelau Nancy m. wadere F. Service &	Jac to md, 21229
23a. Part Lenter the discussion or conshool or be at 11 re. List only Immediate Cause (Final disease or condition resulting in death)	unlications that caused the death. Do not enter the mode of dying cush as parties or requirement arrest	Approximate Interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (cisease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use of the second secon	contribute to the cause of death?
	24a. Was an autopsy performed? 1 □ Yes 2 ☑ No	4b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6	Other (Specify)
27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28b. Time of Work? 28d. Describe how injury occ	curred

1 □Yes

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

031865

2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

3/3/101

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mien-Over Kirch 31. Date filed (Month, Day, Year) State

2. Registrar's Signature

mo

DHMH 17 Rev 1/2001

Registrar

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Deat 1. Decedent's Name (First, Middle Last) Day Month **Physician** NNA 24 200 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner USPITA RAC TIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Mar 28, 1956 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🗷 F Maryland 220-64-2508 51 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 Yes 2 No **Baltimore** N/A Director Marvland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21217 U.S.A. 1031 North Gilmor Street Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 **X**No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ **X**No Black Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Own Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 of the substant of the substan 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental I Important: If item 27 Is marker any Injury or any In Helena O. Summerville Earl B. Fisher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1031 North Gilmor Street Baltimore', Maryland 21217 Joan Riley Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 04/01/08 Baltimore, Maryland Arbutus Memorial Park 4 Donation 5 Dother (Specify)-21. Sonat re of Funeral Service License 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Approximate Interval Between Onset and Death Part1. Enter the disease, or con shock, or heart failure. List only complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) O CARDIA **Physician** JAN /Medical Due to (or as a consequence of): **Examiner** cause that y flot conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transi and death certificate be exec Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. the 9 Unknown 9 Unknown by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. 9 3 Probably 4 ☐ Unknown 2 No page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an has certificate 1∐ Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 1 | Yes 2 | ₩o 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence P 1 Inpatient 6 ☐Other (Specify) After this 28c. Injury at Work? . Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: To the Hospital or Attending 5 Pending investigation Injury 1 Natural 1 🗌 Yes 2 □ No death. 2 Accident Director: filled in by the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and tle of certifie

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

APR 0 1 2008

58

3 Registrar's Signature

		1 - For State Registrar	State OI	wiai yiai K		artment of rtificate o			nontar Hy	Reg. No.	200	18 101	47
Physicia		Decedent's Name (First, Middle	e, Last)						2. Date of De	eath Dav	Ye	3. Time of De	eath
/Medic				Thirleen	Pras				March		100	08 1400	> M
Examin	er	4a. Facility Name (If not institution				4b. City, Town	or Locatio		altimore	4c.	County of D	Peath N/A	
Funeral		5. Social Security Number		. Age (In yrs. Ia		If Under 1 Year Months Day		er 24 Hrs.	8. Date of Bi	rth	9.	Birthplace (State or F Country)	-oreign
Director	2	216-32-7290 Usual Residence of Decedent	1□M 2□ ½	7	73 Yrs.	Months Day	Hours	o IVIIII.		28, 19	934	Maryland	
yland iow		10a. State 10b. County		10c. City,	Town or Lo	ocation	-					10d. Inside City	
death with the Maryland ms 23a or 28a-f show r must be notified at	Director	Maryland	N/A				Baltin	nore				1 □ Yes 2	□No
with th		10e. Street and Number	: Otro ot			10f. Zip Code		21223		10g. Citiz	zen of What	t Country? U.S.A.	
death with ns 23a or must be r	Funeral	639 South Pulask	12. Was Deced	ent Ever in U.S	3. 13.	Was Decedent of			ecify Yes or No	0-	14. Race - A	American Indian,	
after de or item miner r		1 □ Never Married 2 □ Marri	ied Armed Ford 1 ☐ Yes 2 If Yes, Give	P No	i	If Yes, specify Cu 1 ☐ Yes 2 ☐ N			Rićan, etc.)			Vhite, etc.	
ural",	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Date	es:			. ,	ry.			Specify:	Black	
filed within 72 hours after Hygiene. tther than "natural", or ite ant, the Medical Examine	Completed	(Specify only highe	t's Education st grade completed)		(Give	dent's Usual Occ kind of work don DO NOT use reti	e durina m	ost of work	king	16b. Kir		ess/Industry	
d with giene.	Juo?	Elementary/Secondary (0-12)	College (1-4	for 5+)			Homem	naker				Own Home	
be file tal Hy d othe event,	Be	17. Father's Name (First, Middle,	,				18. Mo	ther's Nam	e (First, Middle		Surname)	,	
should ind Men s marke umatic	우	19a. Informant's Name/Relations	Arthur Boyd		10b Maili	ng Address (Stre	at and Nun	nhar ar Pu					
and 2 sl ealth an n 27 is r er traur		Denise Wilson	пр (туре. Епп)		19D. Maiii	639 S. Pul						ie, zip code)	
es 1 a of Hea fitem r othe		20a. Method of Disposition	0 DD	l co	ace of Dispo metery, cre	osition (Name of matory or other p	lace)	1	Date	20c. Lo	cation - City	or Town, State	
permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once.		1 ☐ B X fial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S	Specify)	ate		Mt. Zion Ce		 	04/02/0	8	Lansd	owne, Marylan	d
permit Depart Import any in		21. Signature of Funeral Service	Licensee	1	2:	2. Name and Ado Est	ep Broth	ners Fu	neral Servi	ce, P. A	Δ.		
ERL		23a. Pa 11. Enter the disease, or shock, or heart failure. List	lications that cau	used the seath.	. Do not en	130	0 Eutav	N Place	Raltimore.	Md 21	217	Approximate	
Physician		Immediate Cause (Final	only one cause on eac			E met						Interval Betwe Onset and De	
/Medical		disease or condition resulting in death)	a. Due to (or	a conseque		C MICH	1>1001	10 0	NU X	-		- J VVLOV	LINIS
Examiner	_	Sequentially list conditions,	b	r as a conseque	1. No. 12								
and All-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dae to to	as a conseque	ence or).								
e E :5	Еха	that initiated events resulting in death) Last	CDue to (or	r as a conseque	ence of):								
icate be e physician s the buria	dical												
leath certific attending p	/Mec	IF FEMALE:	23c. If yes, outco	ome of pregnan	ncv						23d. Date of	i deliver	
requires that the death certificate be seen signed by the attending physicis hould be detached for use as the bu	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live bir 4 ☐ Pregna	th 2 Fetal nt at time of de	death 3	⊒Ectopic pregnar ⊒ Other (specify)	псу				Month	Day Ye	ar
at the by the tached	hys	9 □ Unknown	9∐Unknov	vn									
w requires that the d been signed by the should be detached	by	Part II. Other significant conditi	ons contributing to dea	th but not resul	ting in the u	inderlying cause i	jiven in Pa	rt I.		_		te to the cause of dea ☐ Probably 4 ☐Unl	
	eted								24a. Was		202001 M		-
e las has je 2	ompleted								i auto		i prior		se of
ician: Th certificate rector, pag	C	25. Was case referred to medica	1				26. Pla	ace of Dear	1☐ Yes th (Check only		1 🗆 '	Yes 2□No	
hysic his ce Il direc	To B	examiner? 1 ☐ Yes 2 No			R/Outpatie	II JU DOX		Nursing Ho	ome 5□Res	idence 6	6 □Other (Specify)	
Jing P	ion:	27. Manner of Death 1 Matural 5 ☐ Pendir 2 ☐ Accident investi	9	Injury , Day Year)	28b. Time o Injury	W	ury at ork? ⊒ Yes 2	□No	28d. Describe	how injur	y occurred		
Attender death	ficat	3 Suicide 6 Could	not be 28e. Place o	f injury - At hon	ne, farm, st	reet, factory, offic						r Rural Route Numbe	er,
tal or safter	Certification:	4 ☐ Homicide determ	building	g, etc. (Specify))				City or To	own, State)		
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, I	edical ((Check only 2 Medical		sis of examinati	vledge, deat ion and/or ir	th occurred at the evestigation, in m	time, date y opinion, o	and place death occu	, and due to the	e cause(s) e, date and	and manne I place, and	er as stated. due to the cause(s)	
o the lithin 2 o the lo	Med	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month,										fonth, Day, Year)	
F S F 8		A Than	m, U.D.			AT 2438946				March 27, 2008			
3		30. Name and address of person	who completed cause			Print)							
			m. U.D.	Mi	on n	remona	u H	09pi-	tal L	ND			
Sta Registr		31. Date filed (Month, Pay, Year)	2008	gistrar's Signati	e do	and s							

DHMH 17 Rev 1/2001

David Rankin	i
UNK UNK	
	1 F
Physician/	İ
Medical Examiner	
1	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

NK UNK		State of Maryland / Department of Health and Mental Hygiene 1-For State Certificate of Death Reg. No.	10448
Physici	an/	Registrar 1. Decedent's Name (First, Middle Leet) 2. Date of Death Month Day Year 0.740	
ledical Exami	ner	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
		3740 Ravenwood Ave. (In the rear) Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State of Birth)	ate or
Funeral Director		229-37-2125 12M 2 F 21 Yrs. Months Days Hours Min. 5-2-1986 Foreign Country)	MD
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside	e City Limits
Maryland 28a-f show any 1 at once.	or	Baltimore 120	s 2 No
ne Mary or 28a-	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
r death with the Maryland or items 23a or 28a-f sho must be notified at once.	eral [11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.	, Black,
ter death ', or ite	Funeral		
nours aft	eted by	10 To Date:	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mornal Hygenes. Health and Mornal Hygenes. Health and Mornal Hygenes. To have the more than "matural", or items 23a or 28a-fish on ther traumatic event, the Medical Examiner must be notified at once	Complete	Elementary/Secondary (0-12) College (1-4 or 5+) Laborer Construct	ron
ID 21215-00% should be filed within and Mental Hygiene. 7 is marked other the natic event, the Med	Be Col		
212 Dould be ad Menta is mark tic even	To B	1 a. Informant's Name/Relationship (Typ. Lint) 19b. Mailing Address (Street and Number or Rural Rante Number, City or Town, State, Zip Code)
, MD and 2 sho (ealth and tem 27 is		Shirley A · Kankin 4516 Parkside Dt. But 100 212 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, Sta	06 te
MOFE Pages 1 ent of H nt: If i		1 Burial 2 Cremation 3 Removal from State KING MEMORIAL FACK 3/29/2000 Balto-MD	
Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2 Injury or other traun		21. Innature of Funeral Service Licensee 2 Juame and Address of Fronting Constitution (Constitution of Funeral Service Licensee)	
Physician			mate Interval
/Medical xaminer		Immediate Cause (Final disease a. Gunshot Wound to Head	Death
		Sequentially list conditions.	
	Examiner	if any, leading to immediate Due to (or as a consequence of): Cuse. Enter Indentying Couse (Disease or injury that initiated Ci	
uted			
60, tte be execut hysician and e burial - trai	Medical	UNPENDED AMENDED	
3876(rtificate ing phy	an/Me	Z3d. Date of delivery 23b. Was decedent pregnant in the pay 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day	Year
Box 6876 death certificate the attending phy of for use as the	ysician/N	4 Pregnant at time of death 5 Other (Specify)	
P.O. Es that the gned by the edetachec	by Phy		of death?
ds, P.(equires that een signed ould be dets	eted I	24a. Was an 24b. Were autopsy find	ings available
ecor he law r ate has b	Completed	autopsy prior to completion performed? death?	2 No
tal Rection: The certificate	Be C	25. Was case referred to medical 25. Hace or Death (Check only one)	
of Vital Records, ing Physician: The law required the remain of the rema	ပ္	O 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other: Scene	
ivision or Attendin after death. Director: A. In by the fur	ation	The state of the s	
Division spital or Attendiours after death.	Certification:	Suicide 6 Could not be determined (Specify) Alley 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Alley 28f. Location (Street and Number or Rural Route or Town, State) 3740 Ravenwood Ave. (In the rear), Baltim	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans			
To th withi To th	Medical	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Y	
		O.C.M.E. March 23, 2008	
4		30. Name and address of person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201	
s	tate	te 31. Date filed (Man P Ray (feat) 2008 32 Registrar's Signature	
Regis	trar	ar	

68760,	
Box	
P.O.	
Records,	
f Vital	
rision o	

			Amend PII, 25, perME, g881 7/28/08 TT State of Maryland / Department of Health and M	I Copies <i>I</i> lental Hygi	ene and initial
	- VA		1 - State Registrar amend #19a Per Inf G878 4/0ceptficate of Death	Re	g. No.
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) ALPHONSO PITTS ROBINSON, II	2. Date of Death Month	Day Year 3. Time of Death 10.10 P M
	Examin	100	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death GOOD SAMARITAN HOSPITAL BALTIMORE		4c. County of Death N/A
	Funeral Director		5. Social Security Number 6. Sex 1 Age (In yrs. last birthday) 7. Age (In yrs. last birthday) Yrs. 7. Age (In yrs. last birthday) Yrs. 7. Age (In yrs. last birthday) Yrs.	8. Date of Birth (Month, Day, July 19	Year), 1934 9. Birthplace (State or Foreign Country), Maryland
	aryland show	_	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the Mi	Director	Maryland Baltimore County Ruxton 10e. Street and Number 10f. Zip Code	10	Og. Citizen of What Country?
	23a or	rai Di	7810 Chelsea Street 21204		USA
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. In Internative If it is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avent, Ite Meulc. Experiment or it into the notified an once.	by Funerai	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Spit Yes, specify Cuban, Mexican, Puerlo 1 □ Yes 2 ☒ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
0500-c1	"natur	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work done during most of work life. Do NOT use retired)	ing	16b. Kind of Business/Industry
7 7	d withir giene. or than	cmo	Elementary/Secondary (0-12) College (1-4or 5+) 4 Sales Engineer		Johnson Controls
yland	be file at othe avent,	Be	17. Father's Name (First, Middle, Last) Alphonso Pitts Robinson, Jr. Madelin	•	Aaiden Sumame) Boyer
⊂.	should nd Mer marke umatic	10	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura	-	
, Ma	and 2 ealth a m 27 is		Carla Gigges Robinson (Wife) 7810 Chelsea Street, T		Maryland 21204 20c. Location - City or Town, State
nore	ages 1 int of H t: If ite y or otl		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specific) 20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Crematory 3/28		Baltimore, Maryland
Baltimor	permit. P Departme Importan any injur		21. Signature Fun Pervious Lawson (MOU358) 22. Name and Address of Facility MITCHELL—WIEDEFELD 6500 York Road, Bal	FUNERAL	HOME, INC.
۲	- !		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arre	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death) a. ASPIRATION PNEUMON/A Due to (or as a consequence of):	- , /	
	Examiner			1/1/10	MINER
	De A lead	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
Ď	sician and burial-transit	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): CERTIFICATION PROPERTY.		
08/PN	cate be ohysicia the bu	dicai	d		
O. BOX 6	he death certificate b the attending physic ched for use as the b	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \ Yes 2 \ No 9 \ Unknown \ Other (specify) \ 9 \ Unknown \ Other (specify) \ 9 \ Unknown \		23d. Date of delivery Month Day Year
cords, P.	law requires that the deras been signed by the a 2 should be detached to	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. METASTATIC SPINDLE CELL TUMO R		pacco use contribute to the cause of death? as 2 □ No 3 □ Probably 4 □ □ □ □ nknown
Heco	9 4 9	Completed	SEVERE DEBILITY Metastatic spindle cell	24a. Was a autops perform	y prior to completion of cause of death?
Vital	ilcian: Th certificate rector, pag	Be Co	tumor with resulting paraplegia 25. Was case referred to medical examiner? 26. Place of Deat		
O	g Phys er this ieral dii	10			ance 6 Other (Specify) ow injury occurred
DIVISION	or Atten after deal Diractor	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (St City or Town	reet and Number or Rural Route Number, n, State)
	To the Hospital or Attendin within 24 hours after death. To the Funeral Diractor: Att completely filled in by the fun	Medicai C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner stated.	red at the time, d	ate and place, and due to the cause(s)
	To the Comp	M	29b. Signature and title of certifier Sow M.D. 29c. License number DOO 6 6 3 6 9	2	9d. Date signed (<i>Month, Day, Year</i>) 3/3//2008
_	16		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRIYANKA SOIN 5601, LOCH KAVEN BLVD, BAL 31. Date filed (Month Day, Year) APR 2008 32. Registrar's signature	TIMOR	E, MD 21239
	Sta Registr		31. Date filed (Month Day, Year) 8 32. Registrar's signature		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death **Physician** LOUIS ROBINSON IRCh Ŕ. 25 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Social Security Number Birthplace (State or Foreign Country) Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 X M 2 □ F Director 208-07-7330 89 22. 1918 Pennsylvania Usual Residence of Decedent 10c. City. Town or Location 10a, State 10b. County 10d. Inside City Limits show at a or 28a-f sh 1X Yes 2 No Director Maryland Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 108 West Saratoga Street er than "natural", or items 23a the Medical Examiner must b 21201 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No Unk
If Yes, Give 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White 3 ☐ Widowed 4 X Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) SoftDrink Bottling is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 1 and 2 should be filed withi Health and Mental Hygiene. Plant Laborer Manufacturer permit. Pages 1 and 2 should be filed. Department of Health and Mental Hyg Important: If Item 27 is marked other any injury or other traumatic event; 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William M. Robinson Elizabeth Raymous ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Mitchell P.O. Box 128, Cardale, Pennsylvania 15420 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State 3/31/2008 Acklin Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Brownsville, PA 21. Signatur of Funda Serve December 1980 Martin U. Lawson 22. Name and Address of Facility
MITCHELL-WIEDEFELD_FUNERAL HOME, INC York Road, Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of) Examine certificate be executed and Due to (or as a consequence of): Box 68760, aftending physician I for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) I□Yes 2□No P.O. the detached 9 Unknown 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ be 4 Unknown 1 🗌 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate Division or Vital 1☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient P 1 ☐ Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After To the Hospital or Attending within 24 hours after death. 1 Natural 5 ☐ Pending investigation 1 Yes 2 No 2 Accident To the Funeral Director: 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated.

State Registrar

8

29b. Signature and title of

Date filed (Month, Day, Year)

APR U

cmin

2008

1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Morgan Lionel Rich	1- For State	partment of Health and Mental Sertificate of Death	_	2008 1045
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) Morgan lionel Richardson		2. Date of Death Month Day March 22, 200	3. Time of Death
(1)	Facility Name (if not institution, give street and number) 5014 Band Hall Hill Road	4b. City, Town, or Location of De Westminster	ath .	4c. County of Death Carroll
Funeral Director	215-30-9491 1XM 2 F 74	's. last birthday) Yrs. If Under 1 Year If Under 24I Months Days Hours N	8. Date of Birth(MI 01/31/19	W/DD/YYYY) 9. Birthplace (State or Foreign Mary Land Country)
und show any nce.	Usual Residence of Decedent 10a. State 10b. County 10c. C Maryland Carroll	ity, Town or Location Westminster		10d. Inside City Limits 1 Yes 2 X No
vith the Maryland 23a or 28a-f show a potified at once. al Director	10e. Street and Number 5014 Band Hall Hill Road	10f. Zip Code 21157	10g. C	itizen of What Country? U.S.A.
death v or items must be	11. Marital Status 1 Never Married 2 X Married 1 Never Married 2 X Married 1 Never Married 2 X Married 12. Was Decedent Ever in Armed Forces? 1 X Yes 2 No 14 Yes, Give Year 1959 1 Yes, Give Year 1959	If Yes, specify Cuban, Mexican, Pue	rto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner. To Be Completed by F	15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12) College (1-4 or 5+) 4	16a. Decedent's Usual Occupation (Give kind during most of working life. DO NOT use	retired)	. Kind of Business/Industry Teaching
21215-00 buld be filed will be filed will marked other ic event, the Mr. Co. Be Cor	17. Father's Name (First, Middle, Last) Morgan Henry Richardson 19a. Informant's Name/Relationship (Type, Print)	Evely	me (First, Middle, Maide n Thomas	
MD 21 und 2 should ealth and Me em 27 is ma raumatic ex	Morgan L. Richardson / Son	19b. Mailing Address (Street and Number of Art Lane, Ox Ob. Place of Disposition (Name of cemetery,	vings Mills	
Baltimore, permit. Pages I a Department of He Important: If ite	1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	crematory or other place)	1/31 /2009 O	wings Mills, Md.
Physician Physician	21. Signature of Funeral Service Licence 23a. Part I. Enter the disease, or complications that caused the de	- 4011 Park Hgus, AV	e., Baitim	
/Medical kaminer	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardi			Between Onset and Death
ecuted and transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence consequence)	<u> </u>		
execui an and al - tra	d. UNPENDED AMENDED	· · · · · · · · · · · · · · · · · · ·		
D. Box 68760, the death certificate by the attending physiched for use as the burnched for use and Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of p. 1 Live birth 4 Pregnant at time of g Unknown	2 Fetal death 3 Ectopic pre		23d. Date of delivery Month Day Year
ires that the signed by the detache	Part II. Other significant conditions contributing to death but no	ot resulting in the underlying cause given in Part I.		co use contribute to the cause of death? No 3 Probably 4 Unknown
tal Records, cian: The law require: certificate has been signed, page 2 should be Be Completed				24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
n of Vital fing Physician: After this certi funeral director on: To Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No 1 ✓ Yes 2 No 27. Manner of Death 1 ✓ Natural 5 Pending 1 ✓ Natural 1 Pending	26.Place of Death (Che ER/Outpatient 3 DOA Other;4 Nu 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No		dence 6 Other: Scene
Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune-	4 Homicide determined (Specify)	t home, farm, street, factory, office building, etc.	or Town, State)	
To the Hospital within 24 hours. To the Funeral completely filled	one) 2 Medical Examiner: On the basis of examination and manner stated.		ed at the time, date and	place, and due to the cause(s)
	29b. Signature and title of certifier Working The World	29c. License number O.C.M.E.		d. Date signed (Month, Day, Year) arch 23, 2008
2+1	30. Name and address of person who completed cause of death (If Margarita Korell MD. Assistant Medical Example 123 Personal Assistant Medical Example 124 Personal Assistant Medical Example 125 Personal Assistant	niner 111 Penn Street, Baltimore, M	D 21201	
State Registrar	31. Date filed (Month, Day, Year) APR 0 1 2008 32. Registrar's Sign	& book		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Year Month **Physician** Richard C. Roberts 2008 8:25 P March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard 5400 Vantage Point Road Apt E502 Columbia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 26, 1925 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months Days Min 1 XM 2 ☐ F Hours Ohio Cauntry) 293-20-9473 82 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State d other than "natural", or items 23a or 28a-f show event, the fredical Examiner must be notified at 1 ☐ Yes 2 → No Directo Columbia Maryland Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21044 U.S.A. 5400 Vantage Point Road Apt E502 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify. ģ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Hankey Gilbert Roberts ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 permit. Pages 1 and 2 Department of Health Important; If item 27 i any injury or other tra 12226 Valerie Lane Laurel, MD 20708 David L. Roberts 27 (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory 3-29-2008 Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) ^{22.} Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Rd Columbia, MD 21045 W101050 23a. Part1. Enter the headse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METAS AN CER Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Division of Vital Records, P.O. Box 68760 (こん) Division of Vital Records, P.O. Box 68760 (こん) Il or Attending Physician: The law requires that the death certificate be executed Exami D ardiomi the burial-tran resulting in death) Last Due to (or as a consequence of Physician/Medical attending ph IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 5 Other (specify) 9 Unknown 9 Unknown signed by t i be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 1 ☐ Yes 2 ☐ No tors director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (*pecify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Thomicide within 24 hours To the Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c, License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month

altimore, Maryland 21215-0036

32 Registrar's Signature

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year 4.35 PM **Physician** Sister Mary Margaret Rommal, SUSC 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner Balhmore Hanes HOSD IFON Sant 8. Date of Birth (Month, Day, Ye Tan. 13, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Year. 1 □ M 2 1 F 214-14-3720 Ĩ922 Maryland 86 Director Usual Residence of Decedent 10c. City, Town or Location show 10a, State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at 17 Yes 2 □ No Director Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21227 IISA death v 3308 Benson Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married White Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☒ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Department of Health and Mental Important: if Item 27 is marked or any injury or other traumatic eve Pages 1 and 2 should be Dolores Lawrence Albert Rommal 19a. Informant's Name/Relationship (Type. Print) Pers.Rep. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 444 Center Street; Milton, MA Sister Gretchen Marlatt Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 4/2/2008 New Cathedral 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licenses 1901496 MD 21228 1630 Edmondson Avenue; Catonsville, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardia Physician day /Medical Due to (or as a consequence of): douls Examiner bacteremia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) gustro intestinal bleed alsy S upper buriaf-trar Due to (or as a consequence of): physician Physician/Medical attending physic for use as the b IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 🗷 No Day 4□Pregnant at time of death 5 Other (specify) ed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 Tes 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autonsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760,

Hospitai or Attending 24 hours after death • Funeral Director: filled in by within 24 the

> State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) March, 29, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

Ave, Bultimore, MP, 21229

31. Date filed (Month, Day, Year) APR 01 2008

Registrar's Signature

Please Type or Print in Black Indelible Ink. Fragre All Copies Are Legible. Amend Item II per family 6897 II. / 5709 dk & Item I' State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 1:00 **Physician** P^{M} 2008 Stitz March 26, /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Howard Ellicott City 8521 High Ridge Road If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Days **Funeral** Hours 11XM 2□ F 76 Maryland September 11,1931 213-28-0455 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐Yes 2 XNo Ellicott City Maryland Directo Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21043 8521 High Ridge Road 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ≥ 2 XNo
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify Specify: White Baltimore, Maryland 21215-0036 2 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) other than Wal-Mart Special Projects Manager 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be f and Mental I Mary Kester Anton Stitz is marked 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8521 High Ridge Road, Ellicott City, MD. 21043 permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra Susan Stitz -wife-20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) March 31, 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Halethorpe, Maryland Meadowridge Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License. Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part1. Enter the disease, complications that caused the data. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Use only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MINUTES VENTRICULAR **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SYSTEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine physician and street street The law requires that the death certificate be executed HRONIC resulting in death) Last Due to (or as a consequence of) Box 68760, ORONARY Physician/Medical as attending property for use as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 1 ☐Live birth Month Day Year in the past 12 months? 5 ☐ Other (specify) 4☐Pregnant at time of death signed by the a 1 ☐ Yes 2 ☐ No P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division or Vital Records, þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 Yes 2 ₹ certificate ha 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) P 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of contifier MD attrail CAPOI DE SOLS duse of death (Item 23a) (Type, Print) 30. Name and address of person who completed 22 MD 3449 WILKENS AVENUE Suite 300 JONATHAN

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 0 1 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Francios S. Sellers MARCH 31 2008 5:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 ☑ F 168-16-2978 Director 86 May 17 1921 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 ☑ No Director Maryland Baltimore Hunt Valley 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 International Circle 21030 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☒ No Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Secretary Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Julius Schraishuhn Elizabeth Roth ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roscoe S. Sellers (husband) 300 International Circle, Hunt Valley, MD 21030 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) April 01 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Philadelphia Crem. Inc Philadelphia, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part . Enter the disease, or comshdok, or heart failure. List only Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Kows /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transit certificate be executed Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctonic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Division or Vital 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2□ No ပ Inpatient 2 ER/Outpatient 3□ DOA After this Manner of Death Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? Certification: or Attending Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D19855 (MD) 30. Name and a person who completed cause of eath (Item 23a) (Type, Print) 1401 CLARK BYE WALTER IS INTINGER LUTHER VILLE

State Registrar

DHMH 17 Rev 1/200

31. Date filed (Month, Day, Year) **APR 0 1 2008**



Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: After this after death within 24 hours a

2

Certification:

Medical

State Registrar

30. Name and address of person who comple 31. Date filed (Month) Day, Year)

5 ☐ Pending investigation

6 Could not be determined

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

ted cause of death (Item 23a) (Type, Print)

Hospital: 1 ☐ Inpatient

28a. Date of Injury (Month, Day Year)

and manner stated.

205

2 ER/Outpatient

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

3□ DOA

1 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Prince Frederick, MD 20678

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decodent's Name (First, Middle, Last) Time of Death Physician :30 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** timore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Months Min. 1**⊠**M 2□F -32-664 Mary land Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Director MY timore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bace - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ Vo Specify. Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ONSTRUCTION Department of Health and Mental Hygis Important: If item 27 is marked other i any injury or other traumatic event, tt once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be 10 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GRICRO Balto-MD 21212 lary A. Sample 1804 Baltimore, Date 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 F Donation 5 Other (Specify) 3 Removal from State Garrison Forest 31/2000 permit. 21. Signature of Funeral Service Licenses Balto 1965 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Mumor 6 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 55tinctive 707-0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Box 68760, 4 requires that the death certificate be executed and burial-trar Due to (or as a consequence of) physician Physician/Medical as the attending p for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a detached t 9 Unknown 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ð 1 ☐ Yes 2 ☐ No 3 Probably 4 ∏Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 s autopsy performe 1□ Yes 2□No Division or Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 TYes 2 1/10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ within 24 hours after death. To the Funeral Director: After this 27. Manner 1 Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the

State Registrar 29b. Signat

30. Name and address of person w

31. Date filed (Month, Day, Year) APR 0 2008 32. Resistrar's Signature

ompleted cause of death (Item 23a) (Type, Print)

29c. License number

SALTIMURE

29d. Date signed (Month, Day, Year)

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 30, 2008 9:50AM March Marvin R. Southcomb 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore Glen Arm Glen Meadows If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 10/16/1923 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 1**X** M 2□ F 84 216-12-8365 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Baltimore Glen Arm MD. 10f. Zip Code 10a, Citizen of What Country? 10e. Street and Number 21057 USA 11630 Glen Arm Road Apt.# 308 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No If Yes, Give WWII Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black White etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: White 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) B&O Rail Road College (1-4or 5+) Elementary/Secondary (0-12) Cabinetmaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Evelyn Andrews Paul W. Southcomb 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2361 Boston St. Baltimore, Maryland 21224 Cecelia Neville/ Cousin 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemelery, crematory or other place) Evans Funeral Chapel – Bel Air 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 04/01/08 Forest Hill, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signa re of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services 8800 Harford Road Parkville, MD. 21234 23a. Parth. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Image ate Cause (find disease or condition resulting in death) a. Due to (or a a consequence of): Approximate Interval Between Onset and Death Due to (or a a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 1 🔲 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1⊟ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a. State

Funeral

Director

r 28a-f show notified at

them 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be a

within 72 hours after

2 should be fi and Mental F

Pages 1 and 2: ment of Health a

permit. Pages Department of Important: If It any injury or o

Maryland 21215-0036

Baltimore,

Director

Funeral

ģ

Completed

Be

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Examine attending physician and for use as the burial-transit Physician/Medical ate has been signed by the page 2 should be detached Completed by director, Be ို Certification: After within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

To the Hospital or Attending Physician: State

4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

BAUTIMORIE.

28c. Injury at Work? 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

determined

28b. Time of

Injury

1 Deertifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed dause of death (Item 23a) (Type, Print)

CAM

28a. Date of Injury

(Month, Day Year)

27. Manner of Death

2 Accident

3 ☐ Suicide

29a, Certifier

Medical

4 Homicide

31. Date filed (Month, Day, Year)

APR 0 1 2008

Registrar's Signature

670

DHMH 17 Rev 1/2001

Registrar

N CHARUES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Maryla		ent of Health and cate of Death	d Mental Hy	/giene () () ()	10459
	Physici /Medio Examir	cal	1. Decedent's Name (First, Middle, Las Au Co 4a. Fecility Name (If not institution, give	Ann Sc	alf 46.0	City, Town, or Location of D	2. Date of D Month Marc	eath Day Year Ac. County of Dea	//·323/.**
7	Funeral Director	ai J	5. Social Security Number 6. Se 394-50-9846 1	7. Age (In yrs	enter s. last birthday) If Ui Mon	nder i Year If Under 24 iths Days Hears N	Ars. 8. Date of B	rth ay, Year) 9. Bir	thplace (State or Foreign quintry)
	72 hours after death with the Maryland neturel', or items 23a or 28a-f show alses Exertires must be rectified at	ector	10a. State 10b. County MD Hart 10e. Street and Numbers	0	City, Town or Location Be	[Air		10g. Citizen of What C	10d. Inside City Limits 1 ☐ Yes 2 No
	death with ms 23s or	Funeral Director	1700 Prindl 11. Marital Status	12. Was Decedent Ever in		2/0/4 ecedent of Hispanic Origin? specify Cuban, Mexican, Pi	(Specify Yes or N	US /	A erican Indian,
-0036	hours after turel; or ite	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	If Yes, 1 □ Ye	es 2 No Specify:	ierto Rican, etc.)	Specify:	hite
121215-0036	iges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23a or 28a-f show or other traumatic event, if a Medical Examinar man be notified as	Completed	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give kind o	f work done during most of T use retired)		Mont gom	ery Ward
Maryland	should be fund Mental be marked of	To Be	UnknowN 19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailing Add	ress (Street and Number of	N AN	drews	Zip Code)
_	Pages 1 and 2 nent of Health a int: If item 27 Is iry or other tra		20a. Method of Disposition 1 Burial 2 Commation 3	Removal from State	Place of Disposition cemetery, crematory		ve Bol	20c. Location · City or	Town, State
Baltimore	permit. Page Department of Important: If eny injury or once.		4 Donation 5 Other (Specify 21. Signature of Funeral Service Licen	Seet M.	22. Nam	e and Address of Facility Funeral Cha	4 2.10 f D Fo Del 4 (10a	rest HII MD	HIII MIS 21050
3	Physician /Medical		23a. Part 1. Enter the disease, or corps shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a Dementia	of Alz	mode of dying, such as card	diac or respiratory	arrest,	Approximate Interval Between Onset and Death
Exa	ate be executed hysician and he burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse Due to (or as a conse C. Due to (or as a conse d.	equence of):				
P.O. Box 68	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of preging 1 Live birth 2 Fer 4 Pregnant at time of 9 Unknown	ital death 3 □Ectop	ic pregnancy r (specify)		23d. Date of de Month	livery Day Year
	The law requires that the set by the bas been signed by the bage 2 should be detached.	by	Part II. Other significant conditions co	intributing to death but not re	esulting in the underlyi	ng cause given in Part I.		tobacco use contribute to	o the cause of death? robably 4 Unknown
al Reco	n: The law r ficate has be or, page 2 sh	Completed	25. Was case referred to medical				1 ☐ Yes	ormed? death?	utopsy findings available completion of cause of
Division of Vital Records,	To the Hospital or Attending Physician: The I within 24 burs after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	ation: To Be	avaminar?	28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 28b. Time of Injury	Other		one) idence 6 Other (Spe	ncify)
Divis	ital or Atterns after desiral Director	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, street, fac cify)	ctory, office		(Street and Number or Rivn, State)	ural Route Number,
0)	the Hospital in 24 hours a the Funeral I npletely filled	Medicai	one) 2 Medical Exam	ysician: To the best of my kr iner: On the basis of examin and manner stated.	nowledge, death occur nation and/or investiga	rred at the time, date and plation, in my opinion, death o	ace, and due to the courred at the time	cause(s) and manner as date and place, and due	s stated. a to the cause(s)
	vith To	2	29b. Signature and title of certifier	to, m		29c. License number	4	29d. Date signed (Mont	h. Day, Year)
	1		30. Name and address of person who co		em 23a) (Type, Print)	DOOS 835	in mo	21911	
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 1 20	32 Jegistrar's Sign	St. Spark				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month 31, 2008 7:45 P.M Irene Castle Shea March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Towson Baltimore County Holly Hill Nursing Center 7. Age (In yrs. last birthday) 86 Yrs. | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec. 09, 1921 5. Social Security Number 6. Sex Birthplace (State or Foreign
Country) **Funeral** 1□M 2\ F 401-24-3849 Pikeville, Ky. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or Itema 23a or 28a-f ehow The Medical Examiner must be notified at 1 ☐ Yes 2 No Perry Hall Maryland | Baltimore County Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 8731 Silver Hall Road 21128 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes Ž No Specify: Specify: White ð 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72.
Depertment of Health and Mental Hygiene.
Importent: if Item 27 is marked other than "na eny injury or other treumatic event, the Medic once. Social Security Elementary/Secondary (0-12) College (1-4or 5+) n/a Clerk Supervisor Adminis. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Draxie Osborne Willie Flanary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8731 Silver Hall Road Perry Hall, Maryland 21128 Ms. Anna M. Shea (Daughter) 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 20a. Method of Disposition cemetery, crematory or other place)

Joseph Ch.Cem. April 03, 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State Texas, Maryland 4 Donation 5 Other (Specify) 2008 21. Signature of Funeral Service Licenses Peaceful Alternatives Funeral&Cremation Ctr.,P.A 2325 York Road Timonium,Maryland 21093 Part I. She the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final End-Stage **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine ettending physicien and I for use es the buriel-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) P.O. I ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has autopsy performed 1 Yes 2 No the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 X No this 28a. Date of Injury (Month, Day Year) After thi 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending death. 1 TYes 2 No investigation within 24 hours efter death To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 29a. Certifier Decartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified Gendelman MD 30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

205

31. Date filed (Mon

ORIGINAL

38

32 Registrar's Signature

5

RA

2008

Day, Year)

APR 01

08-02414 Patricia Segler

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

itricia Segier		- For State		rtment of Heat tificate of Deat	tn and Mental H Th		g. No.	200	8 1045	
Physicia	n/	Registrar 1. Decedent's Name (First, Middle,Last)				2. Date of Deatl	1	ear	3. Time of Death	
edical Examir	ner	Patricia Segler 4a. Facility Name (if not institution, give street and nu	mb orl	Lab City	Town, or Location of Death	Month March 27,		y of Death	0535 hrs	
		5439 Bel Air Road	mber)	Baltir				N/A		
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la		er 1 Year If Under 24Hrs		h(MM/DD/YY)	(Y) 9. Birth Foreign	place (State or California	
Director		264-08-1648 1 M 2XF		55 Yrs. Month	ns Days Hours Min	July 2	5, 1952	2 Cour	ntry)	
â		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location					10d. Inside City Limits	
nd show a	_	Maryland N/A		Baltimo	re				1 X Yes 2 No	
Aaryla 28a-f	Director	10e. Street and Number	<u> </u>	10f. Zip	Code	10	g. Citizen of V	What Count	ry?	
th the N		5439 Bel Air Road			21206			USA	L. B Disali	
ath wir	Funeral	1 Never Married 2 Married Armed F		S. 13. Was Decede	ent of Hispanic Origin? (S ify Cuban, Mexican, Puerto	Rican, etc.)		ce - America nite, etc.	an Indian, Black,	
frer de	핈	3 Widowed 4 X Divorced If Yes, Give Yes	2 X No	1 Yes 2	No specify:		Specify	v: Whit	te	
nours a	q pa	15. Decedent's Education (Specify only highest grad			Occupation (Give kind of rking life, DO NOT use ret		16b. Kind of I	Business/In	dustry	
36 in 72 l	plet	Elementary/Secondary (0-12) College (1	-4 or 5+)	Bookkeep	er		Car De	alero	shin	
5-00 ed with lygiene other	Completed by	17. Father's Name (First, Middle, Last)		Воокисер	18.Mother's Name	e (First, Middle, N				
1215 I be fill ental H arked	BB	Clyde Ransford		Table and the same		yn Jorda		01-1-	7:- Code)	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ျ	19a. Informant's Name/Relationship (Type, Print) Michael A. Segler, Son			s (Street and Number or Nwoods Way F		-			
e, M I and 2 Health item 2	ı	20a. Method of Disposition		Place of Disposition (Na rematory or other place	me of cemetery,	Date	20c. Locatio	n - City or T	Town, State	
MOF Pages ent of nt: If r other		1 Burial 2 Cremation 3 Removal fr 4 Donation 5 Other Specify:	OIII State	ro Cremato	100	28/08	 Balti	imore.	Maryland	
saltii epartii. aporta jury o	- 1	21. Signature of Funeral Service Licensee	0,		Address of Facility tion Society rederick Roa	Of Mary	land.	Inc.		
1		Thomas Gregor Juman 23a. Part I. Enter the disease, or complications that	aused the death.	- 299 F	rederick Roa	<u>d Baltiñ</u> or respiratory arre	nore. 1	<u>Maryla</u> heart	and 21228 Approximate Interval	
Physician Medical		failure. List only one cause on each line.		ascular Disease	, 3 ,	,			Between Onset and Death	
⁻xaminer			consequence of							
	<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a	consequence of).			_			
	Ē	Cause. Enter Underlying Cause								
γ gg , tight	Exa	events resulting in death) Last Due to (or as a	consequence of):						
Sox 68760, Action to executed death certificate be executed to attending physician and affor use as the burial - transit	Physician/Medical Examiner	UNPENDED AMENDED								
760, icate be extiphysiciar the burial	Me	Oh Mine decedent recognition the	outcome of pregr		2			of delivery	ay Year	
Box 687 death certific he attending p d for use as th	cian	past 12 months?	oirth nant at time of dea	2 Fetal death		aricy	Month	D	ay real	
nof Vital Records, P.O. Box 6871 ing Physician: The law requires that the death certifica After this certificate has been signed by the attending phuneral director, page 2 should be detached for use as the	hysi	1 Yes 2 No 9 V Unknown g Unkn		W 1 M 1 1 1 1	Date of the second	220 Did to	hassa 1100 so.	ptribute to t	he cause of death?	
P.O.		Part II. Other significant conditions contributing to COPD, obesity, hypothyroidism	o death but not re	esulting in the underlyin	g cause given in Part I.				ably 4 Unknown	
ds, equire	Completed by			<u> </u>	-	24a. Was				
e law re has b	du						med? 2 ✔ No	death?	ompletion of cause of s 2 No	
Z E g g g g g g g g g g g g g g g g g g										
n of Vital Records, ing Physician: The law require After this certificate has been si timeral director, page 2 should be	To Be	Tes Z No					Residence 6		Scene	
		27. Manner of Death 1 Natural 5 Pending 28a. Date (Month	of Injury , Day,Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe	now injury occ	urrea		
Division tal or Attendit rs after death. al Director: A	icati	2 Accident Investigation 28e. Plac	e of Injury - At ho	ome, farm, street, factor		28f. Location (S	Street and Nur	mber or Ru	ral Route Number, City	
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined (Specify)			2	or Town, S	itate)			
e Hosp 124 ho e Fune etely f	SalC	29a. Certifier 1 Certifying Physician: To the beautiful Check only	st of my knowledg	ge, death occurred at th	e time, date and place, an	d due to the caus	e(s) and man	ner as state	ed.	
To the within To the Comple	Medical	one) 2 Medical Examiner: On the basis and manner s 29b. Signature and title of certifier	of examination ar tated.		lc. License number	at the time, date			nth, Day, Year)	
		255. Signature and the or default	11		O.C.M.E.		March 27			
J.		30. Name and address of perso o completed cau	se of death (Item							
r\	-14	Jack Titus MD. Deputy Chief Medi	al Examiner	111 Penn Stre	et, Baltimore, MD 2	1201				
Sta Regist	ate	31. Date filed (Mahar, Ray Year) 2008 324	gistrar's Signatu	book						
regist	للتع	I		7						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2008 12:12A M March 28 Kamalaben Soni 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore Gilchrist Center Towson Birthplace (State or Foreign Country)
 India 8. Date of Birth (Month, Day, April 7, 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 1927 Days Hours 1 □ M 2 X F 80 219-78-2511 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐Yes 🎾 No Sykesville Maryland Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21784 USA 1040 Sunset Valley Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2X Married Specify: Asian Indian 1 □Yes 2 🕅 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Somiden Vrajlal Hiralal Soni 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1040 Sunset Valley Drive Sykesville, Maryland 21784 Vithalbhai Soni, Husband 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 03/31/08 Baltimore, Maryland Metro Crematory Inc. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
MacNabb Funeral Home, P.A. Thomas Gregor 301 Frederick Road Cátonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate

Physician /Medical **Examiner**

Physician

Examiner

Funeral

Director

28a-f show

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importants if item 27 is marked other than "natural", or items 23a or 28a-f show amy printy or other traumatic event, the Medical Examiner must be notified at once.

/Medical

10a. State

Funeral Director

ò

Completed

Be

ဥ

Physician/Medical Evam ag/ ş within 24 hours after death

To the Funeral Director:
completely filled in by the

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

shock, or heart failure. List only	one cause on each line.			Onset and Death
Immediate Cause (Final disease or condition resulting in death)		YEARS		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ØNo 9 □ Unknown		topic pregnancy her (specify)	23d. Date of de Month	elivery Day Year
Part II. Other significant conditions of	ontributing to death but not resulting in the under	lying cause given in Part I.	23e. Did tobacco use contribute to	to the cause of death? Probably 4 🔲 Unknown
			autopsy prior to	tutopsy findings available completion of cause of
25. Was case referred to medical		26. Place of Death	(Check only one)	
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	Other: 4 Nursing Hor	me 5 Residence 6 Other (Sp.	ecity) HOSPICE
27. Manner of Death 1	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury		28d. Describe how injury occurred	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, building, etc. (Specify)	28f. Location (Street and Number or F City or Town, State)	Rural Route Number,	
29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exan	ysician: To the best of my knowledge, death oc niner: On the basis of examination and/or invest and manner stated.	curred at the time, date and place, igation, in my opinion, death occurr	and due to the cause(s) and manner and at the time, date and place, and du	as stated. ue to the cause(s)
29h Signature and title of certifier		29c. License number	29d. Date signed (Mor	nth, Day, Year)

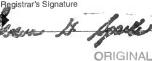
D64395 MARCH 28, 2008

BALTIMORE MO 21204

State Registrar 31. Date filed (Month, Day, Year)

DANIEUE DOBERMAN, MO 6565 NCHAPLES ST, SMITE 209 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM/17, per H (878, 4/1/08 US
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** DONALD SEYMOUR March 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NIA 046 Cooks Laine Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | APRIL 19, 1934 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 □ F 13 Yrs 212-70-6850 Director JAMAICA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. Seymour NIA 1 Yes 2 No MARYLAND BALTIMORE Directo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? LANE S.A. COOKS 1046 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Donald BLACK 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CORRECTION STATE OF MARYLAND OFFICER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stroghn JAMES SEYMAL RONA SEYMOUR ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) IVY SLYMOUR (WIFE) 1046 COOKS LANE, BALTIMORE, MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State LOUDON PARK CEMETER DY-05-2008 BALTIMORE, MARYLAND 4 Donation 5 Other (Specify) 22. Name and Address of Facility 2140 North Fulton Avegue MO 21217 21. Signature of Funeral Service Licensee elliano Brown Jr. Funeral Home Baltimore Joseph 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) tavanced LUNG **Physician** ancer MY /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, is a first conditions, if any, is a first cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of death certificate be execute attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown ate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 certificate 1∐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 🔑 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No death. 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 😕 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD D18587 West's 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave Boltimore MD 21229 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 10e per fh 878 4-2-08 yr State of Maryland / Bepartment of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 13:30 PM Roy Francis Sprinkel MARCH 27th 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ST. AGNES HOSPITAL BALTINORE n/a If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign Country) Maryland 6. Sex 8. Date of Birth (Month, Day, Year) 8 / 22 / 1916 7. Age (In vrs. last birthday) **Funeral** Days Min 1 ₹ M 2 □ F 91 212-01-4578 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Baltimore MD Catonsville 10e. Street and Number Choice Lane #424 717 Maiden Choice Lane #424 10f. Zip Code 10g. Citizen of What Country? 21228 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

★TYPes 2 □ No fives, Give 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: USA 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Steel Mfg. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Wesley Sprinkel Annie Grace Utz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Fay L. Sprinkel / Wife 717 Maiden Choice Ln., Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If it 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Denation 5 ☐ Other (Specify) Evergreen Mem. Park 3/31/2008 Finksburg, Maryland 21 Signatur, of Funeral Service License 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final PNEVHONIA **Physician** UNKNOWN disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CHRONIC OBSTRUCTIVE PULMONARY DISEASE UNKNOUN if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown NIA 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nunknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No or Vital 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death

1 X Natural

2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Division Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide e Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatur@ and title of certifier M.D. D0066262 MARCH 27 41, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 57. AGNES HOSPITAL MAGDALENA STARBAN, M.D. 900 CATON AVE, BALTIMORE 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar APR 01 2008

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 12:25P Vincent J. Sabatino 3-27-2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Lorien Health Care Baltimore Md. If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)

Md. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** 94 1**X** M 2 □ F Yrs. Director 216-05-9301 2-6-1914 Usual Residence of Decedent 10a, State 10h. County 10c. City, Town or Location 10d. Inside City Limits show a or 28a-f show t be notified at 1 ☐ Yes 2 X No Director Md. Balto. Co. Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4015 Shroeder Avenue 21128 USA r items 23a o by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status ral", or item Examiner r Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Italian 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 'natural", Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Purchasing Agent 12th City of Baltimore 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be l and 2 should be fi fealth and Mental H Mariano Sabatino Marianna Gugliuzza or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health a
Important: If item 27 Is
any injury or other trau Dorothy L. Sabatino 4015 Shroeder Avenue Perry Hall, Md. 21128 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State N Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Dulaney Valley 3-29-2008 Timonium, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility D Jeins Schimunek Funeral Home 9705 Belair Rd. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner LUNG DISEASE PHRONIC if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Due to (or as a consequence of) ed by the attending physician detached for use as the buria Box 6876 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division or Vital Records, P.O. 9 I Inknown 9 Unknown sate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending investigation To the Hospital or Attendi within 24 hours after death.
To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated.

State

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

72. Registrar's Signature

D 25643

. Charles Street Seet 209/

29d. Date signed (Month, Day, Year)

Booto MD 21204

3008

Physicia /Medica Examine

Funeral

Registrar Decedent's Name (First, Middle, Last) SIDNEY							eg. No.	4111	1 1 1 00 1
SIDNEY						2. Date of Deat			3. Time of Death
DIDITI	MURDOCK	SELLMAN	V			Month MAR	Day 20	Year 108	10:04 P ^M
. Facility Name (If not institution, give s		- DIJIJI III		b. City, Town, or	Location of Deat		_	ounty of Dea	
NATIONAL NAVAL MED	ICAL CEN	ΓER		BETI	HESDA		M	ONTGO	MERY
Social Security Number 6. Sex	7. Ag	e (In yrs. last bir		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Year)	9. Bir	thplace (State or Foreign
264-46-3939	M 2 🛣 7 (5	Yrs. "	Month Buyo	TIOGIO IVIIII.	Jan. 12	, 193	2 F	lorida
sual Residence of Decedent Oa. State 10b. County		10c. City, Tow	n or Locat	tion					10d. Inside City Limits
				1011					1 ☐ Yes XXNo
Virginia Fairfax De. Street and Number		Vien		105 75- 0-1-			0- 011	n of What Co	
				10f. Zip Code				n or what Co	ountry r
9508 Spinet Court	2. Was Decedent I	Ever in U.S.	13 1/12	22182	enanic Origin? (9		JSA 14	Bace - Ame	erican Indian,
. Marital Status 1 1 ☐ Never Married 2 ☑ Married	Armed Forces?		If Y	es, specify Cuba	n, Mexican, Puer	Specify Yes or No- to Rican, etc.)	'-	Black, Whit	
3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	••	1 🗆	Yes 2 X No	Specify:		Si	pecify: Wh	ite
15. Decedent's Educ		16a.		nt's Usual Occupa			16b. Kind	of Business	/Industry
(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5	i+)	(Give kin life. DO	nd of work done d NOT use retired,	uring most of wo)	orking			
Elementary/occordary (0-12)	2	′	mema	ker			0wn	Home	
7. Father's Name (First, Middle, Last)					18. Mother's Na	me (First, Middle, I	_		
Clifford Sidney Mu	rdock Jr.				Thelma .	Arringtor	ı		
9a. Informant's Name/Relationship (Typ	ne. Print)	19b	. Mailing /	Address (Street a	and Number or R	ural Route Number	; City or T	own, State,	Zip Code)
Edmund William Sel	lman	95	08 S	pinet Co	ourt. Vi	enna, Va.	221	82	
a. Method of Disposition		20b. Place of	f Dispositi	on (Name of tory or other place	i				Town, State
1XXBurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State			National	· i	/29/08 A	rlin	otan.	Virginia
1. Signature of Pureral Service License	e			lame and Addres		, _ , , , ,			. Maple Ave
all St. A. Linelle		0968	Mon	ev & Kir	g Funer	al Home.			na, Va.2218
nmediate Cause (Final issease or condition sculting in death) equentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury at initiated events sculting in death) Last	Due to (or as	JMONIA a consequence a consequence	of):						Onset and Death
d. FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	3c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death		otopic pregnancy ther (specify)			230	d. Date of de Month	elivery Day Year
art II. Other significant conditions conf	tributing to death bu	ut not resulting ir	n the unde	erlying cause give	n in Part I.				o the cause of death? 'robably 4 ∐Unknowi
						24a. Was a autops perform	n sy med? 2 🌠 No	24b. Were a prior to death? 1 ☐ Yes	utopsy findings available completion of cause of s 2 No
5. Was case referred to medical examiner?	ospital:			3 DOA Othe	r.	ath (Check only on			
I res ZXX NO	1 A Inpatie		<u>'</u>	OLI DON	4 Li Nursing i	Home 5 ☐ Reside			ecify)
27. Manner of Death 1 X Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28c. Date of Injury at Work? 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred								lural Route Number,	
9a. Certifier 1 Certifying Phys	er: On the basis of	f examination an	e, death o	ccurred at the timestigation, in my op	ne, date and place	e, and due to the c curred at the time, d	ause(s) ar	nd manner a	s stated.
one)	and manner sta	itea.							

State Registrar

HANS C. ACKERMAN 31. Date filed (Month, Day, Year)

APR 0 1 2008

M.D. 32 Registrar's Signature

BETHESDA MD 20889-5600

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Ma	-	epartment Certificate		nd Mental Hy	/giene Reg. No. 201	08 10467		
Physician /Medical			1. Decedent's Name (First, Middle, Last) Denise Lynn Sizemore			2. Date of D Month March		3. Time of Death 11:45a			
0	Examin		4a. Facility Name (If not institution, give street and number) 124 King Charles Circ	le		own, or Location of sedale	Death	4c. County of Balt	Death Limore		
	Funeral Director		214-58-8914 1 M 2 TyF	6 (In yrs. last birth 56 Y	hday) If Under 1 Months I		Min. 8. Date of Bi	ar, Yerr952	9. Birthplace (State or Foreign Country) MD		
	e Maryland Ba-f show tified at	ctor	Usual Residence of Decedent 10a. State	10c. City, Town	Rosedal				10d. Inside City Limits 1		
	th with th 23a or 24 ust be no	Funeral Director	124 King Charles Circl	.e	10f. Zip C	ode 21237		10g. Citizen of Wh	at Country?		
036	al", o	ρ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent E Armed Forces? 1 □ Yes Z ☒ N If Yes, Give Year or Dates:	lo	1 ☐ Yes 2	XNo Specify:	n? (Specify Yes or N Puerto Rican, etc.)		American Indian, White, etc. White		
21215-0036	l within 72 he jene. r than "natu the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5		Decedent's Usual (Give kind of work life. DO NOT use eamstre	Occupation done during most of retired) SS	of working	16b. Kind of Busi	,		
land 2	be d o d	To Be C	17. Father's Name (First, Middle, Last) Larry A. Hutton				s Name <i>(First, Middle</i> ris Wats				
Maryland	4.4 th		19a. Informant's Name/Relationship (Type. Print) James Sizemore / sor.	- 1			or Rural Route Num. les Circ	-	tate, Zip Code)		
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other	Ì	20a. Method of Disposition 1☆ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	20b. Place of I cemetery Crown	Disposition (Name y, crematory or oth SVILLE	of er place) VA	Date 4/3/08	20c. Location - C Crowns	ity or Town, State		
Balti	permit. Pages 1 Department of H Important: If ite any Injury or ot once.		21. Sign re of uneral Service Liconsee	2 2		Address of Facility			Balto. MD sex 21221		
	Physician	o y	23a. Part Enter the disease Confidence that caused shock, or heart failure. List only one cause on chill immediate Cause (Final disease or condition resulting in death)	atu E	ot enter the mode	of dying, such as ca		arrest,	Approximate Interval Between Onset and Death		
30/05 11:45°0 68760,	Medical Examiner bhysician and s the bruial-trusis	dical Examiner	Due to (or as a consequence or): Securities Securiti								
3 (Box	requires that the death certificen signed by the attending I hould be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 □Ectopic prec 5 □ Other (spec			23d. Date Mont	,		
Died rds, P.C	es the igne	þ	Part II. Other significant conditions contributing to death bu	it not resulting in	the underlying cau	se given in Part I.		./	oute to the cause of death? B □ Probably 4 □ Unknown		
al Recor	The law ate has b page 2 sl	Completed					24a. Wa aut per 1 Yes	opsy pri formęd2 de	ere autopsy findings available for to completion of cause of lath? □Yes 2 □ No		
Sizemore n or Vital Re		To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatie		·	Other: 4 Nurs		sidence 6 □Other			
ō	Attending ir death. ector; After by the funer	Certification:	27. Manner of Death 1 Natural 5 □ Pending investigation 2 □ Accident 3 □ Suicide 4 □ Homicide 4 □ Homicide 4 □ Accident 28e. Place of injunction (Month, Day (M	Year) In	m, street, factory, o	c. Injury at Work? 1 ☐ Yes 2 ☐ No office	28f. Location	Street and Number	or Rural Route Number,		
Denise Divisi	Hospital or 4 hours afte Funeral Dir tely filled in		29a. Certifier (Check only 2 Medical Examiner: On the basis of	of my knowledge,	, death occurred at	the time, date and	place, and due to th	e cause(s) and man			
	To the within 24	Medical	29b. Signature and title of certifier **Deal Color of Certifier Color of C	T.M.D.	29c. i	License number	>	29d. Date/signed	(Month, Day, Year)		
	3	-	30. Name and address of person who completed gause of de	7 eath (Item 23a) (7 M.D	Type, Print)	Charles	Street,	Bertomo	r, MP 21212		
	Sta Registr	_	21 (2011)	ar's Signature	estes		-				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-02378 2008 10466 State of Maryland / Department of Health and Mental Hygiene Roland Reno Scott Certificate of Death 1- For State Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Roland Reno / Scott, II Physician/ March 26, 2008 0738 hrs Examiner 4c. County of Death 4b. City, Town or Location of Death Facility Name (if not institution, give street and number **Baltimore** University of Maryland Medical Center 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreign Min. Months Davs Hours Country) Director 1 XM 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No Altimore notified at once. Director 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number USA 1217 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S 11. Marital Status marked other than "natural", or items event, the Medical Examiner must be Armed Forces? Never Married HMERICAN Yes If Yes, Give Year 2 X No specify: Yes 4 Divorced þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) more, MD 21215-0036
Pages 1 and 2 should be filed within 72 leart of Health and Mental Hygiene. Gue INC. Warehouse Worker 24 18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last) Be Keno 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type, Print) spouses nt: If item 27 is no other traumatic And 21217 20c. Lócation - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition Baltimore, crematory or other place) 2 X Cremation 3 Removal from State permit. Pages
Department of
Important: I DAHIMORE. []JARY CRematore Conation 5 Other Specify: 22 Name and Address of acility WATLACE FUNERAL SERVICE 3405 W. FRANKLIN St. BAHIMORE, MARLIA nature of Funeral Service Licensee Part I. Ent. The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interva ysician Between Onset and Death Madical Shotgun wound of abdomen Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last AMENDED #1,23a,27,28a-f, Item#18perFH,G893. Physician/Medical 9/5/08 TT X UNPENDED attending physician or use as the burial 23d. Date of delivery Box 68760 23c. If yes, outcome of pregnancy Day Year Month 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions o 1 Yes 2 No 3 Probably 4 Unknown Completed by Records, P. 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy certificate has b rector, page 2 sh death? performed? ✓ Yes 2 No 1 V Yes 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be Other₄ Nursing Home 5 Residence 6 Hospital: 1 / Inpatient 2 DOA ER/Outpatient 3 this 1 🗸 Yes ဥ No 28d. Describe how injury occurred subject shot self with defective weapon 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year 28b. Time of Injury After 27. Manner of Death Certification: To the Hospital or Attending within 24 hours after death. Yes 2X No 1 Natural 3/26/2008 during assault Pending Fnd Fo the Funeral Director: completely filled in by the 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 410 Laurens St. Baltimore, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide determined (Specify) street Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Registrar

DHMH 17 Rev 1/2001 **OCME 2006**

29b. Signature and title of certifier

30. Name and address of person who comple

Theodore M. King, Jr., MD.

31. Date filed (Month, Day, Year) APR 0 I 2008

ORIGINAL

29c. License number

O.C.M.E.

OCME

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

March 27, 2008

and manner stated

ted cause of death (Item 23a)

32. Registrar's Signature

Assistant Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 10:35 PM SHURE MARSHALL R. 03 26 800x /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner LEVINDALE HEBREW HOME BALTIMORE Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/28/1935 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 □ F Yrs. 215-32-5841 72 MD Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location o other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 NYes 2 No Director MD N/A BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f Zin Code 6318 GREENSPRING AVENUE, APT. 103 21209 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XX Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 XNever Married 2 Married 1 ☐ Yes 2 🕻 No Specify: WHITE Maryland 21215-0036 ð 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) permit. Pagas 1 and 2 should be filled will Department of Health and Mental Hygien. Important: If them 27 is marken other the my Injury or other traumatic. ATTORNEY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **BERNARD** SHURE MARIAN ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RICHARD M. SHURE / BROTHER 10 FIVE OAKS COURT, OWINGS MILLS, MD 21117 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State BETH TFILOH CONG. 03/30/2008 BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Vatur M. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Lemen 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) nysician CANCER METHSTHIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Lines of deliving Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of). Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 □Unknown 2 No 1 ☐ Yes 24a Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1□ Yes 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Hospital: Other: Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

after death. 24 hours a

the within 2 To the I

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29a. Certifier

(Check only one)

PHYSICIAN

and manner stated.

D0064533

29c. License number

29d. Date signed (Month, Day, Year) 03 27/2007

MD 21215

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEVINDITE - HEBLEW BARATUNDE

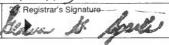
GERIATRIC 2434 W. BEZVEDERE AVE BATTIMORE

Registrar

0

Medical

31. Date filed (Month, Day, Year) APR 0 1 2008



ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

			For	State of Ma		d / Depart	ment of I	Health an		ntal Hyg	jiene	2000	1.01	-7
			1 - State Registrar			Centi	ficate of	Death			eg. Na	2000	104	
	Physici /Medic		1. Decedent's Name (First, Middle, Last HERBERT		101	NAS	JR	•		Date of Dea Month March	Day 2		3. Time of 2 24	Death A M
1	Examin		4a. Facility Name (If not institution, give	street and number)	,	4	b. City, Town,	or Location of E	Death			County of Dea		
			1-uture Care			1		DAL			C	SALTI	MORE	_
	Funeral Director		217-20-2616	X 7. Age	(In yrs. 78		f Under 1 Year fonths Days	If Under 24 Hours	Min.	Date of Birth (Month, Day BRUARY	Year)	9. Bi	thplace (State of ountry)	r Foreign
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Locat	ion						10d. Inside Cit	tv Limits
	e Maryl Ba-f sho	ctor	MARYLAND N/A			ALTIM		CIT	TY				1 Yes	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or items 23a or 28a-f show any injury or other traumatic svant, the Modical Exert for mention modified at once.	Funeral Director	10e. Street and Number 205 S. BAC	100 0	200		10f. Zip Code	213		1	-	izen of What C	_ ′	
	dea	ner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.	S. 13. Wa	s Decedent of I	Hispanic Origin an, Mexican, F	? (Specif	y Yes or No-		14. Race - Am		
21215-0036	urs after al', or Ita	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 STV-0 OF N	02-18		Yes 2 2 No		- delto mic	an, etc.,		Specify:	LACK	
50	72 ho	ted	15. Decedent's Edu	cation	-	16a. Deceden	t's Usual Occu	oation			16b. Ki	ind of Business	/Industry	
215	ithin 7	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. DO	NOT use retire							
	ygien ygien t, Lie	Co	11TH GRADE			TRUC	KI	DRIVE						
Maryland	be fill Hall Hall Hall Hall of other svan	Be	17. Father's Name (First, Middle, Last)	Tido m	100	,				irst, Middle, i	Maiden		0.11	
y la	ould Men Parke	P	HERBERT	THOM	173			THELMA and Number or Rural Route Number			BROW			
Mai	12 sh h and 7 ls n traun		19a. Informant's Name/Relationship (Ty		6)						-		Zip Code) Q/Q/	,2
	1 and Healt am 2 ther		20a. Method of Disposition	<u> </u>					Date			ocation - City or		<u> </u>
ō	nt of nt of nt of nor o		1 ⊠Burial 2 ☐ Cremation 3 ☐ F		_	lace of Disposition		1 1/2 2					LLS, MAI	RVIAU
Baltimore,	artme artme ortani njury	1	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens		GAR	RISON F	ame and Addre	-111-					reque MO	
Ba	Depa Impo any Ir		in the h	1/12)	lai	22. N	anne and Addit	1	,	1 '		4.4	//	
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused	the death	Do not enter t	13 <i>eph 1+</i>	ng such as cal				TTOME	Approximate	9
	% Observation	Ì	Immediate Cause (Final		~ .		,	3,		,	,		Interval Bety Onset and D	veen
1.	Physician /Medical		disease or condition resulting in death)	a		etes								
	Examiner			Due to (or as a	<u> </u>	ience or):								
4,		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a		1 4 4				-				-
	d d ansit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events		tu	whos	٢							
oʻ	te be executed ysicien and e burial-transit		resulting in death) Last	Due to (or as a	conseq	uence of):								
3760,	nte be nysicie	ical		d										
89	ng ph	Med	IF FEMALE:											
Вох	ith ce tendi	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome o			topic pregnanc	y			1	23d. Date of de	-	
o.	the a	sici	1 Yes 2 No	4□ Pregnant at t 9□ Unknown	eath 5 🗆 O	Other (specify)					Month	Day Y	'ear	
P.O.	that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit	by Physician/Med	Part II. Other significant conditions cor	ntributing to death bu	not resu	ulting in the unde	riving cause on	en in Part I		23e. Did tol	nacco u	ise contribute t	o the cause of de	eath?
ds,	es De d	d by					ny mg caddo g.				es 2[1	Inknown
Ö	w rec	Completed							_	24a. Was a	n	24h Were a	utopsy findings a	available
Be	he lav e has	m C								autops perform	y ned?	death?	utopsy findings a completion of ca	iuse of
a	icien: Th certificate rector, pag	0	25. Was case referred to medical					26 Place of	Death (C	1 ☐ Yes :	No.	1 U Ye	s 2 No	
\geq	ysici is cer direct	ToB	examiner?	lospital: 1 ☐ Inpatien	t 2 🗆	ER/Outpatient	3□ DOA O#					6 □Other (Spe	acify)	
ō	g Physical dispersal di	2	27. Manner of Death	28a. Date of Injury (Month, Day	Year)	28b. Time of Injury	28c. Inju	ry at		. Describe ho			,,	
Ö	ath. or: Af	atio	1 Natural 5 Pending 2 Accident investigation	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, 54.7			Yes 2 □ No						
Division of Vital Records,	after de Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - At no (Specify	me, farm, street,	factory, office		28f	Location (St City or Town	reet an n, State	eet and Number or Rural Route Number, State)		
_	Hospi 4 hou Funer ely fill	Medical C	(Check only 2 Medical Exami	sician: To the best of ner: On the basis of e	examinat	wledge, death oc ion and/or invest	curred at the ti	me, date and p	olace, and	due to the ca	ause(s)	and manner a	s stated. e to the cause(s)	1
	To the P within 2 To the P complete	Med	onej	and manner state	ed.		29c. Licens							
	5 × 5 0		29b. Signature and title of certifier			MIZ	230. LICONS	3/1/	1.	2	Ju. Dal	e signed (Mon	III, Day, 18ar)	
,		-	100047	/				-71 X P	7		7	4	, ,	
	かて		30. Name and address of person who co		ath (Item	23a) (Type, Prin	13 52	5-t	71	20 13	60.	1	MD 21	201
	Sta	e	31. Date filed (Month, Day, Year)	32. He gistrar	's Signa	inte s	/V 3 d	, ,,,,,	الــ عن	7 /) rUV	rm 1	الله دا	- 41
	Registra		APR 0 1 20	08 2000	-	H Agas	S.							

Dec. Herbert Thomas

Second Content of Second Con				1 - For Stete Registrar		State o	f Marylai	nd / Depa	artmen <i>rtificat</i>			and M		giene Reg. No.	008	}	0472
PARCIAL D. A County of Death A County of	П	Physici	an												Ye		3. Time of Death
THOSE CLEN ARW ROAD APT. L66 Support Notice of CLEN ARW ROAD APT. L66	,												MARCH				7:11 P. M
Second Secretify Number Second Second Number Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Second Number Second Number Second Number Second Second Number Second Number Second Second Number Second Nu		Examir	ner		_							of Death			•		
The state of the s		Cureval										24 Hrs.	8. Date of Bir	th			
Usual Passengona of Discounts 100. Clarky 100. Clark									Months	Days	Hours	Min.	(Month, Da	ıy, Year)		Country	1)
DONALD HAMTLTON, SR. 19a. Informant's Named Relationship (Type. Prev) 19b. Malling Address (Street and Number or Fuzzal Ricuse Number, City or Town, State, 2/6 Code) MARY CARA STEWART/NECE P.O. Box 165 GLEN ARM, M2 21057 20b. Named of Department of Companion o		P .		Usual Residence of Decedent									10/0/				
DONALD HAMILTON, SR. 19a. Informant's Namendeationaring (Type. Pret) 19b. Mailing Address (Street and Number or Futual Route Number of Growth Route Number of Route Number of Growth Route Number of Route Nu		show	_													100	
DONALD HAMTLTON, SR. 19a. Informant's Named Relationship (Type. Prev) 19b. Malling Address (Street and Number or Fuzzal Ricuse Number, City or Town, State, 2/6 Code) MARY CARA STEWART/NECE P.O. Box 165 GLEN ARM, M2 21057 20b. Named of Department of Companion o		he M 28a-f	ecto		MORE		G	LEN ARI		Codo				10m Citi	of 14/h a	t Countr	
DONALD HAMTLTON, SR. 19a. Informant's Named Relationship (Type. Prev) 19b. Malling Address (Street and Number or Fuzzal Ricuse Number, City or Town, State, 2/6 Code) MARY CARA STEWART/NECE P.O. Box 165 GLEN ARM, M2 21057 20b. Named of Department of Companion o		with a or	Ö		4 DO 4	D 4 D/I			TOI. ZIP		~~~			rog. Citi		(Country	y:
DONALD HAMTLTON, SR. 19a. Informant's Named Relationship (Type. Prev) 19b. Malling Address (Street and Number or Fuzzal Ricuse Number, City or Town, State, 2/6 Code) MARY CARA STEWART/NECE P.O. Box 165 GLEN ARM, M2 21057 20b. Named of Department of Companion o		ns 23	era			2. Was Dece	dent Ever in t	J.S. 13.	Was Deced			gin? (Spe	ecity Yes or No)-		American	Indian,
DONALD HAMTLTON, SR. 19a. Informant's Named Relationship (Type. Prev) 19b. Malling Address (Street and Number or Fuzzal Ricuse Number, City or Town, State, 2/6 Code) MARY CARA STEWART/NECE P.O. Box 165 GLEN ARM, M2 21057 20b. Named of Department of Companion o	LO	or Itar	F		ırried	1 ☐ Yes	2 X No					Puerto	Rican, etc.)			Vhite, etc	C.
DONALD HAMTLTON, SR. 19a. Informant's Named Relationship (Type. Prev) 19b. Malling Address (Street and Number or Fuzzal Ricuse Number, City or Town, State, 2/6 Code) MARY CARA STEWART/NECE P.O. Box 165 GLEN ARM, M2 21057 20b. Named of Department of Companion o	8	rel', c	d by	3 X Widowed 4 ☐ Divorce	ed	Year or D	ates:		1 Li Yes	ZIXI NO	Бреспу:				Specify:	VHII	E
DONALD HAMTLTON, SR. 19a. Informant's Named Relationship (Type. Prev) 19b. Malling Address (Street and Number or Fuzzal Ricuse Number, City or Town, State, 2/6 Code) MARY CARA STEWART/NECE P.O. Box 165 GLEN ARM, M2 21057 20b. Named of Department of Companion o	2	72 h	iete((Give	kind of wo	rk done a	lurina most	of worki	ing	16b. Ki	nd of Busin	ess/Indu	stry
DONALD HAMTLTON, SR. 19a. Informant's Named Relationship (Type. Prev) 19b. Malling Address (Street and Number or Fuzzal Ricuse Number, City or Town, State, 2/6 Code) MARY CARA STEWART/NECE P.O. Box 165 GLEN ARM, M2 21057 20b. Named of Department of Companion o	12	within ane. then	mp	Elementary/Secondary (0-12)							,			OF	NI LION	ır	
MARY CARA STEWART/NIECE P.O. Box 165 GLEN ARM, MD 21057 20a Mandred of Disposition 1/2 Burial 2 Commands a Deposition (Name of Commands) 20b Flance of Deposition (Name of Commands) 20b Flance of Deposition (Name of Commands) 21 Signature of Flance (Roadford) 22 Signature of Flance (Roadford) 22 Signature of Flance (Roadford) 22 Signature of Flance (Roadford) 22 Signature of Flance (Roadford) 22 Signature of Flance (Roadford) 22 Signature of Flance (Roadford) 22 Signature of Flance (Roadford) 22 Signature of Flance (Roadford) 22 Signature of Flance (Roadford) 22 Signature of Flance (Roadford) 23 Signature of Flance (Roadford) 24 Signature of Flance (Roadford) 25 Sequentially list conditions commands of Plance (Roadford) 26 Sequentially list conditions commands of Plance (Roadford) 27 Sequentially list conditions commands of Plance (Roadford) 28 Sequentially list conditions commands of Plance (Roadford) 29 Sequentially list conditions commands of Plance (Roadford) 29 Sequentially list conditions commands of Plance (Roadford) 20 Sequentially list conditions commands of Plance (Roadford) 20 Sequentially list conditions commands of Plance (Roadford) 20 Sequentially list conditions commands of Plance (Roadford) 20 Sequentially list conditions commands of Plance (Roadford) 20 Sequentially list conditions commands of Plance (Roadford) 20 Sequentially list conditions commands of Plance (Roadford) 20 Sequentially list conditions commands of Plance (Roadford) 20 Sequentially list conditions commands of Plance (Roadford) 20 Sequentially list conditions commands of Plance (Roadford) 21 Sequentially list conditions commands of Plance (Roadford) 22 Sequentially list conditions commands of Plance (Roadford) 23 Sequentially list conditions commands of Plance (Roadford) 25 Sequentially list conditions commands of Plance (Roadford) 26 Sequentially list conditions commands of Plance (Roadford) 27 Sequentially list conditions commands of Plance (Roadford) 28 Sequentially list conditions com	2	filled Hygie ther	ပိ	17. Father's Name (First, Middle		IEARS		III	JNENAL	LEA	18. Mothe	r's Name	(First, Middle			<u></u>	
MARY CARA STEWART/NIECE P.O. Box 165 GLEN ARM, MD 21057 Date 00c Location - City of Town, State owner of the control of the	an	ld be ental kad c	o B	DONALD HAMTLE	YOM.	SR.					ΜΔΙ	R. TOR	TE BURT	MC			
MARY CARA STEWART/NIECE P.O. Box 165 GLEN ARM, MD 21057 Date 00c Location - City of Town, State owner of the control of the	ary	shou and M mar umat	-		-			19b. Maili	ng Address	(Street a					Town, Sta	te, Zip C	ode)
Recommendation of the part 12 portions Part P		and 2 rallth 2 rallth 27 li		MARY CARA STEW	ART/	NIECE		P.O.	Вох	165	GLE	N AR	M, MD	2105	7		
Section Companies Compan	ore				3 □ ₽4	amoval from	1	Place of Dispo cemetery, crei	osition (Nam matory or o	ne of ther place				20c. Lo	cation - Cit	or Town	n, State
Section Companies Compan	Ĕ	Pag ment ant: I ury o					DR										
Section Companies Compan	gall	ermit.		21. Signature of Funeral Service	e license	• 1	ncm										
The state of the		ACCOUNT SOLI ECCH RAVEIN BLVD. 10										, MD					
Process of the part of the par	Į,	Priysician		Immediate Cause (Final	st only on	M A	1	al in	Jan	elin	~	our diao c	or respiratory a			1r	nterval Between
Sequentially list conditions: Say Useful Sequentially list conditions Sequentially list conditions Sequentially list conditions	Ĺ	/Medical			r a	De to (or as a conse	quence of):	1								
The first interest and overlap in the first of delivery in the past 12 mg mins? Due to (or as a consequence of):		⊏xaminer	L	Sequentially list conditions,	b			University of the Control									
The first interest and overlap in the first of delivery in the past 12 mg mins? Due to (or as a consequence of):		pe / d/ is	ine	tany leading to intrediate cause. Enter Underlying Cause (Disease or injury	₹	Due to (or as a consu	quence or):									
Section Sect		xecut and	xan	that initiated events	c.	Due to (or as a conse	quence of):									
FFEMALE: 1 1 20 1 1 1 1 1 1 1 1 1	9	e be e sician burià	aiE														
Section Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1	Ó	ifficate g phy as the	edic		0.												
Section Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1	ŏ	th cer endin r use	an/N	23b. Was decedent pregnant	23				Tectopic or	eonancv				2			
The property of the property o		0 0	sici	1 ☐ Yes 2 🗹 No		4∐Pregn	ant at time of								Month	U	ay Teal
1 Yes 2 Mo 3 Probably 4 Unknown 24a. Was an autopsy findings available profer to completion of cause of death? 25. Was case referred to medical examiner? 1 Yes 2 No Hospital: Impatient 2 ER/Outpatient 3 DOA 27. Many of of Death 1 Yes 2 No Hospital: Impatient 2 ER/Outpatient 3 DOA 28b. Place of Death (Check only one) 27. Many of of Death 1 Yes 2 No Year) 28d. Date of Injury 28d. Date of Injury 28d. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28d. Describe how injury occurred 1 Yes 2 No 28d. Describe how injury occurred 28d. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Certifier 1 Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29d. Dat	<u>.</u>	hat th d by I			tions con	tributing to de	ath but not re	culting in the u	nderlyina c	auca awa	n in Part I		23a Did t	obacco u	se contribu	te to the	cause of death?
Second S	ďs,	uires t signe Ild be c		ratti. Other significant contain	CONT	anbating to de		saiting in the d	riderlying C	auso give							
Second S	<u> </u>	s beer	olete												24b. Wer	e autops	y findings available
The state of the s	Ä	е <u>г</u> е	шo										perfo	ormed?	dea:	h?	
The state of the s	<u>ta</u>	ien: rtifica ctor, p	0	25. Was case referred to medic	al						26. Place	of Death					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		hysic his ce I dire		1 ☐ Yes 2 ☐ No	H	1 🗆 1				DA	4 LI Nu	rsing Ho	me 5 Hesi	dence 6	□Other (Specify)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Ĕ	ing P	ion:	1 Natural 5 ☐ Pend		28a. Date of (Mont	of Injury h, Day Year)					- 10	28d. Describe	how injur	occurred /		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	<u>s</u>	ttend death stor: ,	icat	3 ☐ Suicide 6 ☐ Could	not be	28a Placa	of Injury - At h	nome farm str			10S 2		28f Location (Street an	d Number o	r Rural F	Route Number
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	2	l or A after Direct	ertii	4 Homicide deter	minea	buildir	ng, etc. (Spec	ify)	001, 1401019	, 011100			City or To	wn, State,			,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		spita hours inerel y filled		29a. Certifier 1 Certify	ing Phys	ician: To the	best of my kn	owledge, deat	h occurred	at the tim	ie, date an	d place,	and due to the	cause(s)	and manne	r as stat	ed.
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		he Hc in 24 he Fu bletely	edic		I Exemin			ation and/or in	vestigation,	, in my op	oinion, deat	th occurr	ed at the time,	date and	place, and	due to th	ne cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M DHM M CMMC 670 N CHARLES ST SYTIMORE MD 21204 State Begistrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature		To ti withi To ti	Ž	29b. Signature and title of certif	ier	7, 1.	x M	0	290		2.2			29d. Dat	signed (A	fonth, Da	ay, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M DMM M D CMMC 6 D N CHARUES ST SYMMORE MD 2/204 State Begistrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature	and a			· ruch	.W	ren	1	7,		30	455			Hym	01,	20	0
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		10		30. Name and address of perso	n who cor	Sand ru	11	A/	Chal	ues	51		BUTIN	ort	, 1	MO	21204
						32 R	egistrar's Sign	ature don	de								

DHMH 17 Rev 1/2001

Registrar

D

Webb, James

State

Avenue

Baltimore imD, 21229

Caton

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TARIO MAHMOOD

APR 0 1 2008

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 10474 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death WILMOUTH **Physician** ELSIE Month 03 1441 フジンソン /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 966 Falls Ridge Way Gambrills Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 223-28-4305 87 Yrs. Director March 9, 1921 Virginia Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location itam 27 is markad other than "natural", or itams 23a or 28a-f show other traumetic event, the Medical Examinar must be notified at 10d. Inside City Limits Director Yes 2□ No Maryland N/A Baltimore 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with it Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "nature" any injury or other traumatic event 10f. Zip Code 10g. Citizen of What Country? Funeral 6421 Danville Avenue 21224 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: \$ 3X Widowed 4 ☐ Divorced Specify: White Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 years Machine Operator Manufacturing 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) George Robertson ၉ Lottie Atkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores Voss Daughter 966 Falls Ridge Way, Gambrills, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition April 1 20c. Location - City or Town, State Oak Lawn Cemetery N Burial 2 ☐ Cremation 3 ☐ Removal from State Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2008 re of Funezal Service Licensee 22. Name and Address of Facility Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) 6MOS Examiner Due to (or as a consequence of) Physician/Medical Examiner requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): physician a Due to (or as a consequence of): resulting in death) Last as esn for signed by the aid be detached for P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 □ No 3 Probably 4 Unknown of Vital Records, þ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? been page 2 s certificate has 1 ☐ Yes 1 ☐ Yes 2 ☐ No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify ٩ 1 Yes 2 No After this 27. Manner of Death Certification: 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 □ Accident 5 Pending death. investigation heral Diractor: A filled in by the f 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) or A efter 4 - Homicide To the Hospital within 24 hours e 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29c. License number 29d. Date signed.(Month. Dav. Year) pleted cause of death (Item 23a) (Type, DUENSE MAH WAY A NNAPOLIS MOVIYO

Registrar's Signature

DHMH 16 Rav 6/95

State

Registrar

31. Date filed (Month, Day, Year)

APR 0

1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month 8:15 PM 03 30 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Monterey *saltimore* 8. Date of Birth (Month, Day, Year) 8.13.198 ecurity Number 7. Age (In yrs. last birthday) If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. 10 M 2 □ F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner πυετ hο ποτίθεσα αt 10c. City, Town or Location 10a. State 10d. Inside City Limits 1€ Yes 2 No Director Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f, Zip Code Mon teres *a 1218* Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2**☐ No**If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) lerk the tai 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edmond Watson ပ eloise 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3818 Monterey Ad Baltimore, MD 27218 atherine A Watson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Greenmant nant 4/1/2008 Baltimore, MD
22. Name and Address of Facility Cremation Services 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License C. Sheene 5151 Baltimore National Pike Baltimore, MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Anaplatic A
Due to (or s a consequence of) year AsTiocytoma resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Ordering Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 → No 24a. Was an 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After t 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

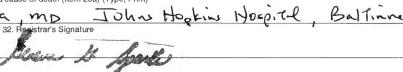
DHMH 17 Rev 1/2001

ate 31. Date filed Wonth, Day, Year) rar APR 0 1 20

address of person

aterra

30. Name and



MD

ho completed cause of death (Item 23a) (Type, Print)

ORIGINAL

D37018

4-01-2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** WALKER FLORINE 5:45 AM MARCH 26 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 □ M 2 □ € 218-42-967 Director Maryland and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1. Yes 2 No Director MD timore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ISA DOOD Funeral 12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify 3 ☐ Widowed 4 Divorced Year or Dates: yad "natural", 15. Decedent's Education (Specify only highest grade completed) the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) ild sager other traumatic event. 17. Father's Name (First, Middle, Last) 18. Moth er's Name (First, Middle, Maiden Surnai Be permit. Pages 1 and 2 should be f Department of Health and Mental I Important; If Item 27 is marked of any injury or other traumatic eve Mental 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sister Balto.MD 2/215 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 R 3 ☐Removal from State Baltimore, MD 4-1-2008 21. Signature of Funeral Service Licenses M01363 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of the shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician SEPSIS 3 days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ASPIRATION PNEUMONIA Sequentially list conditions, if any leafing the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed and burial-tra Due to (or as a consequence of) P.O. Box 68760. attending physician Physician/Medical the as IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for Month Year Day 4□Pregnant at time of death 5 Other (specify) the page 2 should be detached 9 Unknown 9 Unknow by signed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 24a. Was an has autopsy perform this certificate 2 director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗌 Yes npatient 2 ER/Outpatient 3 ☐ DOA filled in by the funeral Date of Injury 27. Manner of Teath 28a 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Director: After (Month, Day or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

or Vital Records, within 24 hours a

To the Funeral L To the Hospital

State

Registrar

31. Date filed (Month, Day, Year) APR 01

29b. Signature and title of certifier

JASON TUROWSKI THE JOHNS HOPKINS HOSPITAL GOO NORTH WOLFE STREET BALTIMORE MARYLAND 21287 32. Redistrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

MEDICAL DOLTOR

29c. License number

RGS-000

29d. Date signed (Month, Day, Year) MARCH 26, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Margaret Anna Warfield 30, 5:45 A M March 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Timonium Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) Days Hours Months 1 □ M 2 💢 F 89 218**-**07-9259 March 29, 1919 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Towson Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 935 Dunellen Drive 21286 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frank Bernard Mills Anna Vorrath 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 935 Dunellen Drive Towson, Maryland 21286 M. Kathleen Miller, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 03/31/08 Baltimore, Maryland 21. Signature of Funeral Service Licensee

Thomas Gregory 22. Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ALZHEIMER'S DISEASE disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Mo 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 V Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

use as the burial-trans pate has been signed by the attending physician and page 2 should be detached for use as the burial-tran requires that the death certificate be execu March 30, 200 P.O. Box 68760, After this certificate

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

permit. Pages 1 and 2 should be flied within 72 hours after a Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examiner

Physician

/Medical

Examiner

5:45A.M. Baltimore, Maryland 21215-0036

Directo

Funeral

Completed by

Be (

2

Physician/Medical Examiner

Completed by

Be

Certification: To

Medical

29a, Certifier

death with the Maryland

Division or Vital Records, or Attending Physician: Warfield, To the Hospital or within 24 hours af To the Funeral D

State

Registrar

Corazon Soares,

Children Car

29b. Signature and title of eettifier

2300 Dulaney Valley Road Timonium, MD, 21093

1 M Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D 110619

29d. Date signed (Month, Day, Year) march 31.

MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) 32. Registrar's Signature

APR 0 1 2008

DHMH 17 Rev 1/2001

08-02342

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	2	0	0	8			0	-	7	0
--	---	---	---	---	--	--	---	---	---	---

nothy Williams	1- F	State of Maryland / Department of Headth State State of Maryland / Department of Headth State Reg. No.
/ Physician		aistrar 2. Date of Death Decedent's Name (First, Middle,Last) Month Day Year 1710 hrs
et xamine	r	Decedent's Name (First, Middle, Last) Williams Month Day Feat 1710 hrs Month March 24, 2008 4c. County of Death
	48	Baltimore
Europal	5.	Serial Security Number 6 Sex 2 7, Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8, Date of Birth (MM/DD/YYYY) 9, Dimpleto (Country)
Funeral Director		715-86-1226 1MM 2 F 42 Yrs. Months Days Hours Min. 05-10-1965 maryland
		Sual Residence of Decedent 10d. Inside City Limits 10d. County 10d. County 10d. County
v any	10	oa. State
daryland 28a-f show any 1 at once.		Md. N/A DaiT was 10g. Citizen of What Country? Oe. Street and Number 10g. Citizen of What Country?
ne Maryland or 28a-f sho fied at once.	Director	23.23 MacCullarah St. Ast 181 21217
vith th		12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black, White, etc. 14. Race - American Indian, Black, White, etc.
death v	Funeral	1 Never Married 2 Married 1 Yes 2 No
after ral", o	~ I	3 Widowed 4 Divolced in Dates: 160 December's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry
hours		during most of working life. DO NOT use retired)
136 thin 72 te. than edical	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) A SSISTANT Foreman Craft Foods 12th N/A A SSISTANT Foreman Craft Foods 18. Mighter's Name (First, Middle, Maiden Surname)
215-0036 // State death with the Maryland he filed within 72 hours after death with the Maryland ntal Hygiene. Red other than "natural", or items 23a or 28a-f shrent, the Medical Examiner must be notified at once		18. Festboric Name (First Middle Last)
21215-0036 Uld be filed within 72 hours after Mental Hygiene marked other than "natural": c event, the Medical Examine	Be	John A: Williams SR. Quen Esther refood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
		ma-lone South - Sister 2833 Winchester St. Rutto, Mai 21216
- 5 8 5 1	_ <u> </u> -	20b. Place of Disposition (Name of cemetery,
TOF Pages ent of nt: If	- [4 Donation 5 Other Specify:
Baltimore permit. Pages 1s Department of He Important: If it	t	1 march fift for the state of
	-	Approximate Interval Between Onset and
`vsician ledical		failure/List only one cause on each line.
⊨xaminer		Immediate Cause (Final disease or condition resulting in death) a. Drabetes Recognizations is a Drabetes recognization of the condition resulting in death) Due to (or as a consequence of):
		Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):
	nine	cause. Enter Underlying Cause
ed nsit	Examiner	events resulting in death) Last
50, tte be executed nysician and e burial - transit	Medical	W UNPENDED AMENDED 23a,27 per ME g878 4/16/08 amh
60, ate be ohysici ne buri	Med	23d. Date of delivery 23d. Date of delivery Year
6876 certificat anding physe as the	ian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month By Month By Month By
tal Records, P.O. Box 68760, cian: The law requires that the death certificate by certificate has been signed by the attending physic ector, page 2 should be detached for use as the bur	Physician/A	1 Yes 2 No 9 Unknown g Unknown g Unknown 23e. Did tobacco use contribute to the cause of death?
P.O. It es that the igned by the detacher	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown
S, P nires then a signeral dead	ed b	24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of
ord: aw requas bee	plet	autopsy performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
Rec The la ricate h	Completed	26.Place of Death (Check only one)
ital Fician: s certificector,		examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene
n of Vital Records, ding Physician: The law requir L After this certificate has been s funeral director, page 2 should 1	<u>ا:</u>	1 Ves 2 No 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year)
ision (Attendin or death.	tior	1 X Natural 5 Pending Investigation Accident Investigation Pending Investigation Inves
Division tal or Attendir rs after death.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number of Rural Route Number, only or Town, State)
DIVI Ospital or hours after an or after yet yet led in yet led in yet led in yet led in hour an or an	Se	4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s)
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for u	edical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Application of the cause(s) and due to the cause(s) and due t
To with	Med	29b. Signature and title of certifier 29c. License number O.C.M.E. March 25, 2008
		aute
		30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
	Stat	Aria Robio IVID.
Regi	Stat stra	ALUD U TOUR BURNESS OF THE STATE OF THE STAT

Physician /Medical Examiner

Funeral

Director

"natural", or items 23a or 28a-f show dical Examiner must be notified at

the Medical

end 2 should be filed within teath and Mental Hygiene.
n 27 is marked other than "i

permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked of any injury or other traumatic ew

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

The law requires that the death certificate be executed and burial-trar attending physician for use as the buria use the þ or Attending after death Director:

Division or Vital Records, P.O. Box 68760,

Ö	CARLIN	OMA PROSTIRATE, 1 Yes 2 No 1 Yes 2 No
ė	25. Was case referred to medical	26. Place of Death (Check only one)
9	examiner? 1 ☐ Yes 2 🛪 No	Hospital: 1 Annatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)
lification:	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio	
Certific	3 ☐ Suicide 6 ☐ Could not be determined	
ca	29a. Certifier 1 To Certifying Pl (Check only 2 Medical Exa	nysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. miner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

(Check only one)	
 	-

and manner stated 29c. License number 29d. Date signed (Month, Day, Year)

b. Signature and title	f certifier
	5

MD D 23300

MARCH 27 2008

SUDHIR.	PATEL.

BON SELOURS HOSPITA). 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 13A2TO, ST. 13A2TO MD. 21223

State Registrar

24 hours a Funeral I Hospital

within 2.

	1- State of Maryland State of Maryland	d / Department of Health and N Certificate of Death	lental Hygiene Reg. No. 2008	0480
Physician /Medical	Decedent's Name (First, Middle, Last) Margaret A. Wilson		2. Date of Death March 28, 22008 Year 9:45	A. M
Examiner	4a. Facility Name (If not institution, give street and number) 6216 Marietta Avenue	4b. City, Town, or Location of Death Baltimore	4c. County of Death	
Funeral Director	5. Social Security Number 215-09-7083 6. Sex 1 M 2 X F 7. Age (In yrs. I	ast birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth May 22, 1909 9. Birthplace (Str County yla	ate or Foreign and
Maryland f show led at	Maryland N/A R	r, Town or Location altimore		le City Limits Yes 2 ☐ No
with the Mar 3a or 28a-f sl st be notified	10e. Street and Number 6216 Marietta Avenue	10f. Zi 27214	10g. Citi ang A f What Country?	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show way injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	S. 13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	ecify Yes or No- Rican, etc.) 14. Race - American India Black, White, etc. Specify: White	٦,
Maryland 21215-0036 d 2 should be filed within 72 hours at th and Mental Hygiene. 27 Is marked other than "natural", or traumatic event, the Medical Exam To Be Completed by I	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Clerk	ing 16b. Kind of Business/Industry Life Insurance Cor	mpany
Viand 2 Vuld be filed Mental Hyg arked other atic event, t	17. Father's Name (First, Middle, Last) Harry E. Wilson		e (First, Middle, Maiden Surname) K. Snyder	
y, Mary and 2 shou salth and M 27 Is mar er traumat	19a. Informant's Name/Relationship (Type. Print) Bernard Wamhoff/Attorney	19b. Mailing Address (Street and Number or Run 5007 Plymouth Road Baltimo	al Route Number, City or Town, State, Zip Code) ne Maryland 21214	
Saltimore, permit. Pages 1 ar Department of Hea mportant: If Item 2 my injury or other 2008.	ADDraid ODormatics ODDrawalfan Chat	lace of Disposition (Name of emetery, crematory or other place) kwood Cemetery 4/1,	Date 20c. Location - City or Town, Stat 108 Baltimore Marylan	
Balt permit. Depart Imports any inj	21. Signature of Funeral Service Licensee		timore Maryland 21214	
Physician /Medical Examiner	23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of the condition resulting in death)	ian Cances	or respiratory arrest, Approx Interval Onset a	imate Between and Death
je je	Sequentially list conditions, if any, leading to immediate cause. Lines University Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of the consequen		9	
BOX (Bath certing attending for use a	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ► No 9 □ Unknown 23c. If yes, outcome pf pregnant 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	death 3 ☐ Ectopic pregnancy	23d. Date of delivery Month Day	Year
Cords, P.O. w requires that the de been signed by the should be detached leted by Physic	11 AN	lting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause	e of death?
The law ate has beage 2 st			24a. Was an autopsy findi prior to completion death? 1 Yes 2 No 1 Yes 2 No	
Or VITal H Physician: The this certificate h ral director, page: To Be Com:	25. Was case referred to medical examiner? 1 Yes 27 No	ER/Outpatient 3 DOA Other: 4 Nursing Ho	7 3	
ding ding Affer fune	27. Manner of Teath 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28b. Time of lnjury at Work? M 1 Yes 2 No	28d. Describe how injury occurred	
To the Hospital or Attentiviting 24 hours after death To the Funeral Director: completely filled in by the Medical Certifical	4 Homicide determined building, etc. (Specify	4	28f. Location (Street and Number or Rural Route City or Town, State)	Number,
To the Hosp within 24 hou To the Fune completely fi		wledge, death occurred at the time, date and place, ion and/or investigation, in my opinion, death occur 29c. License number		
5	· Chalini (Camo)	· D39788	3/28/08	
20	30. Name and address of person who completed cause of death (Itèm DR. Shalim Kamal 9512) 31. Date filed (Month, Day, Year) 32. Registrar's Signat	Hartord Road Carr	ey Mary Land 21234	1
State Registrar	31. Date filed (Month, Day, Year) APR 0 1 2008 33. Registrar's Signat	Soul		
DHMH 17 Rev 1/2001		ORIGINAL		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No LUU8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Mary Anna Wolf 2008 arch /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 12/26/1933 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 🛛 F Mary land 74 220-74-9632 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10b. County 1 ☐ Yes 2 🔀 No Director MD Washington Hagerstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be r 21740 U.S.A. 1712 Ready Parkway Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify <u>م</u> Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A Dependent 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Dorothy Hoefel Robert Henry Wolf, Sr. ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5924 Meadow Road, Baltimore, MD 21206 Leona Marion Alexander, Sister Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 04/03/2008 Baltimore, Maryland Baltimore Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** wo NOW /Medical Disease Due to (or as a consequence of): Examiner KNON: Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical IF FEMALE nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has 1□ Yes 2☑No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient ပို 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Hospital or Attending 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records, within 24 hours after death. To the Funeral Director: A To the

Registrar

29b. Signature and title of certifier

ARID

31. Date filed (Month, Day, Year) APR 0 1 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29d. Date signed (Month, Day, Year)

29c. License number

7060396

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 2003 March /Medical Patricia Ann Wengerd 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Agnes Hospital Baltimore saint N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 11/8/1945 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Min 1 □ M 2√2 F 62 Yrs Maryland Director 214-44-6027 Usual Residence of Decedent or 28a-f show e notified at 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland | Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? o a Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or Items 23a or 10 marked other than "natural", or Items 23a or 10 marked other than "natural", or Items 23a or 10 marked other than "natural", or Items 23a or 10 marked other than "natural", or Items 23a or 10 marked other than "natural" or Items 23a or 10 marked other than 10 mark r items 23a c iner must be 725 Marianne Lane 21228 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※XNo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten edical Examiner Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No White Specify: 3 ☐ Widowed 4 🖾 Divorced er than "natur t, the Medical E 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Customer Service BGE Home years Item 27 is marked other other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward J. Kelly Margaret A. Daily ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2702 Summerview Way Unit 301 Annapolis MD 21401 Mrs. Kathy Marshall (sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 3/31/2008 Towson, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part Errer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician backremia days resulting in death) /Medical Due to (or as a consequence of) Examiner Uterine months Cance Sequentially list conditions, if any, leading to himediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit Cardiomyopat Due to (or as a consequence of Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

Yes 2 No certificate 1∐ Yes Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA Certification: To 0 completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Director; 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March, 26, 2008

State Registrar 31. Date filed (Month, Day, Year)

0

DHMH 17 Rev 1/2001

Wengerd

Caton Ave,

22. Registrar's Signature

Baltimore, MD 21229

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend #30 PER DVR G878 4/06 of Death Reg. No. 3 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Robert Eldridge Wood 0535 M 2008 March 30 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Easton Memorial Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1⊠M 2□F 218-10-7309 Director 88 Maryland July 30,1919 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location r 28a-f show notified at 10a. State 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland | Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be 24850 Woods Drive 21629 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 □ No
If Yes, Give
Year or Dates: 1942-45 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: White Specify. ģ 3₺ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Master Plumber Plumbing Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mentai tem 27 Is marked o Pages 1 and 2 should be Arthur Riggs Wood Elsie Asendorf 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Wood Dibbern Daughter 24850 Woods Drive; Denton, Maryland 21629 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of I any Injury or 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Metro Crematory 3/31/2008 Catonsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service License 1401490 1630 Edmondson Avenue: Catonsville. MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Nonoligieric renal for lure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed NOWMI that initiated events resulting in death) Last and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, the attending physician Pereumoura Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ∐ Yes certificate 2 No 2□ No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Nnpatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No after death 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral E 29a, Certifier 1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of cortifier 29c. License number 29d. Date signed (Month, Day, Year) 00059487 3/30 08

12+1

State Registrar 30. Name and address of

John

31. Date filed (Month, Day, Year)

Botsis

APR 0 1 2008

DHMH 17 Rev 1/2001

Easton, MD. 21601

219 S. Washington Street
32. pegistrar's Signature

erson who completed cause of death (Item 23a) (Type, Print)

Delver

Brer	nda Withers	pooi	1- For State	tate of Maryla		tment of		d Mental H		2(008 048			
	Physic	an/	Registrar 1. Decedent's Name (First, Mide	dle,Last)					2. Date of Deat	eg. No. h	3. Time of Death			
Med	dical Exam		Brenda Wit	herspoon					Month March 24,	Day Year 2008	2115 hrs			
5			4a. Facility Name (if not instituti	ion, give street and nu	mber)	4	b. City, Town, or	Location of Deat	h	4c. County of				
			Greater Baltimore Me				Baltimore			Baltimore				
	Funeral Director		Social Security Number	6. Sex	7. Age (In yrs. last	t birthday)	If Under 1 Year Months Days		n.		 Birthplace (State or Foreign Country) 			
	Director		216 - 90-5868	1M 2X.XF	41	Yrs.			7/31/	1966	Md.			
	any		Usual Residence of Decedent 10a. State 10b. County	,	10c. City. To	own or Location	on .			10d. Inside City				
	d 10 w a										1 XYes 2 No			
	ırylan sa-f si	Director	Md. B	altimore	WII	itema	1'S II 10f. Zip Code		110	0g. Citizen of Wha				
	he Ma or 28 fried	Jire	107 1	W	A + M			7						
1	with t is 23a e not	107 Aspenwood Way - Apt M 21237							USA - 14. Race - American Indian, Black,					
1	leath ritem rust b	Funeral	1 X Never Married 2 N	Married Armed Fo	orces?	If Ye	es, specify Cuban	, Mexican, Puert	o Rican, etc.)	White,				
1	after d 11", on ner m		3 Widowed 4 Divorced in res, give rear 1 Yes 27 No specify: Specify:								lack			
/	ours :		15. Decedent's Education (Sp	ecify only highest grad	de completed) 1		's Usual Occupation of working life.			16b. Kind of Busi				
	6 n 72 h an "n ical E	lete	Elementary/Secondary (0-12	College (1	I-4 or 5+)	duling inc	ist of working life.	DO NOT use le	urea)					
	5-0036 ted within 7 Hygiene. other than	Completed	12		E	x.Ass	t.Dep.(Comm.Co	orr.	Dept.Co	rrections.			
	filed I Hyg		17. Father's Name (First, Middle	∍, Last)					e (First, Middle, N	,				
	2121 wild be fill Mental I marked c event,	To Be	Leroy Cole 19a. Informant's Name/Relation	iship (Type, Print.)		19b Mailing			Withe Num	rspoon ber, City or Town,	State Zin Code)			
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland permit of Health and Menlal Hygiene. Important: If it amarked other than "naturalt", or items 23a or 28a-f show injury or other trannatie event, the Medical Examiner must be notified at once.	_	Cynthia But								Md. 21207			
	and and Health		20a. Method of Disposition			ace of Disposi	tion (Name of cen	netery,	Date	20c. Location - C	ity or Town, State			
	MOFE, Pages 1 ar	-	1 X Burial 2 Crematic		OIII State	ematory or oth		D1 D /	1 /0000	717 * 3	11177 117			
	Baltin permit. P Departme Importan		4 Donation 5 Other 8 21. Signature of Funeral Service		// IKin						r Mill, Md			
	Dep Dem	. 3	Guanof lett	4 Vila	MX L	1 1	step Bi 300 Eut	cotners	Funer	al Serv timore,	ice, PA Md. 21217			
	Physician		23a. Part I Enter the disease, o	r complications that	used the de th. D	o not enter th	e mode of dying,	such as cardiac	or respiratory arre	est, shock, or hear	Approximate Interval			
1	Medical		fail re. List only one cause Immediate Cause (Final diseas		y arrest	occurin	g during i	intravenou	ıs druw sec	lation for	Between Onset and Death			
	.kaminer		or condition resulting in death)	Due to (or as a	consequence of):	tumescen	t liposuct	cion	2 414 50	AGCION TOI				
		_	Sequentially list conditions,	b										
		ine	if any, leading to immediate cause. Enter Underlying Cause		consequence of);									
	- H	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):									
	O, te be executed ysician and burial - transit													
	O, the exe sician sician	edical	X UNPENDED	255,559,	28a-f, perl	ME,g879	5/13/08 TI							
	Sox 6876C death certificate e attending phys I for use as the bh	Σ	IF FEMALE: 23b. Was decedent pregnant in	23c. If yes, o	outcome of pregna	ncy				23d. Date of de	-			
	K 68	cia	past 12 months?		ant at time of death	<u>, - = </u>	aldeath 3 [er(Specify)	Ectopic pregr	iancy	Month	Day Year			
	Box 6876 e death certificate the attending phy ed for use as the t	Physici	1 Yes 2 No 9 Ur	nknown 9 Unkno	own	- Cui	(0,000.)/							
	P.O. es that the igned by to be detache	by PI	Part II. Other significant condi	tions contributing to	death but not resu	ulting in the ur	nderlying cause g	iven in Part I.			ute to the cause of death?			
	cords, P.O. law requires that the has been signed by 2 should be detach								1 Yes	2 V No 3	Probably 4 Unknown			
	cords law requires has been 2 should	jet							24a. Was autop		ere autopsy findings available or to completion of cause of			
	tecc The lar ate ha	Completed							perfor 1 Yes	m <u>ed</u> ? de	ath? ✓ Yes 2 No			
	Vital Rec ysician: The his certificate director, page	Be C	25. Was case referred to medica				26.Place	of Death (Check						
	examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other; Nursing Home 5 Residence 6 Other:										Other:			
To be a graph of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury									28d. Describe t	now injury occurred	1			
	Sion Vitend death. ctor:	Certification:	Pen	nding estigation 3/20/	2008		AM 1 Y	es 2 X No	unk					
	IVIS or A after Direct	ı≅	3 Suicide 6 X Cou	uld not be 28e. Place	e of Injury - At hom		t, factory, office bi	uilding, etc.	28f. Location (S	Street and Number	or Rural Route Number, City			
	Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	ë	4 Homicide	ermined (Specify)	surgical	l center			1300 Bel	lona Ave.	Lutherville, MD			
	he Ho in 24 he Fu	ca		Physician: To the bes aminer: On the basis o										
_	To the within To the comple	Medical	2 Medical Example 29b. Signature and title of certific	and manner st	tated.	,or investigation	29c. License		at the time, date					
	0010-		255. Signature and true of Certiff	0			O.C.N			March 28, 20	(Month, Day, Year)			
	Don't		Clarket	elly)			0.0.1	V 1 - 6		Walter 20, 20	, , , , , , , , , , , , , , , , , , ,			
	1 Bay		30. Name and address of person Laron Locke MD. A	n who completed caus Assistant Medical	•	•	Street, Baltim	nore. MD 21	201					
		ate		489	gistrar's Signature		The Deligit	.5.5, 1410 21.						
	Regis	ale	31. Date filed (MAPPR ay Year)	2008	aux . K	Boar	100							

DHMH 17 Rev 1/2001 OCME 2006

Amend #25, perME, g884 10/29/08 TT Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 23a per dr., g878, 04/01/08dhb.

Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 43 am **Christine Woodard** 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and numb 4b_City, Town, or Location of Death Examiner altimore N/A If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign 6 Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 □ F Yrs. Director 218-60-7401 56 Feb 28, 1952 Marvland Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ **X**es 2 ☐ No Director **Baltimore** N/A Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with U.S.A. 3314 Cardenas Avenue 21213 death v by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumattc event, the Medical Examiner 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State Of Maryland Secretary 12 Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Bryan Mary Bryan ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3314 Cardenas Avenue Baltimore, Maryland 21213 Joseph Bryan Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 □ Berial 2 □ Cremation 3 □ Removal from State 03/17/08 Baltimore, Md. 4 □ Donation 5 □ Other (Specify) Western Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1309 Eutaw Place Paltimore, Md 21217
Do not enter the mode of dying, such as cardiac or respiratory arrest, Malm 23a. Part1. E. or the disease, or complications that caused the deshock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Approximate Interval Between Onset and Death + Encephalopathy Physician /Medical Due to (r as a consequence of): Examiner Acute Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of) Examiner requires that the death certificate be executed and Due to (or as a consequence of): attending physician Division or Vital Records. P.O. Box 68760 Physician/Medical as the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1☐Yes 2☐No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 🗹 Unknown 2 No 3 Probably 1 🗋 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No certificate has 1☐ Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1**X** Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Reedma m.0Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. ¿ 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 0515 AM Marc 2008 Philemon Wilks /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Baltimore Good Samaritan Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 1 □ N 2 □ F So. Carolina 63 Aug 9, 1944 Director 250-70-6770 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. Count d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 □¥es 2 □ No Director N/A Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A 6437 Town Brooke - Apt D 21207 by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 □ Never Married 2 □ Married 1 □ Yes 2 □ **1**% p Specify. Black 3 ☐ Widowed 4 ☐ Doworced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r Baltimore Gas & Electric Co. Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked o any injury or other traumatic eve Essie D. Wilks Robert L. Wilks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2637 South Main Street Winston Salem, No. Carolina 27127 Philemon Wilks Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 3/31/2008 Catonsville, Md. Crematory mature of Friheral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Futaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that cluse the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Covonary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner requires that the death certificate be executed MYOCANDI that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) o detached 9□Unknown 9 TUnknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? Records, ₫ 1 ☐ Yes 2 ☐ No 3 robably 4 □Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No autopsy performed Vital Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To ō this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

or Attending dea h.

Hospitai

within 24 hours a er dea h.

To the Funeral Director A completely filled n by the fr

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature, and title of cention

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Stephen T. Na Unon Memorial Hospital 20/80st University Parking Baltimare

31. Date filed (Month, Day, Year)

1 👇 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

T. Nguyen, M.D.

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend 1 tem 28d per me 88/9 5-5-08 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month AM 2008 20 0527 /Medical towa Ma 23 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Maryland Ral hynch rear If Under 24 Hrs scal N/A university of 200 CVC 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ N 2 □ F Yrs. Director 212-01-9094 Nov 8, 1913 Maryland 94 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hydiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ **X**es 2 ☐ No Director Armold Maryland Anne Arundel 10e. Street and Number 10g. Citizen of What Country? 10f Zin Code 21012 U.S.A. 55 East Joyce Lane Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify δ Specify. Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, the Mea one, once." Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Handy Man 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Whiting Ella Green ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Warren White Nephew 619 Melville Avenue Baltimore, Maryland 21218 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Commation 3 Removal from State 4 Donation 5 Other (Specify) 03/26/08 Catonsville, Maryland Metro Crematory, Inc. 21. Signature of Funeral Service Lice vee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 degent 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, wheart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** disease or condition resulting in death) Due to (or as a consequence of c day /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMINES. Examiner Due to (or as a consequence of) The law requires that the death certificate be executed ed by the attending physician and condetached for use as the burial-transit Muter Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 I Inknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an was ... autopsy performed? Yes 2 XNo has page 2 certificate 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ★ es 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 1 Natural 5 Pending investigation Injury 2011 ded with 2 files 28f. Location (Street and Number or Rura 28f. City or Town, State) For Town State) 03-18-2008 10:12 A death. 1 🗌 Yes 2 Accident truc within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a Certifier Medical (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 0066108 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Simme 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrer	State of Maryland	d / Depar <i>Cert</i>	rtment of F	lealth and Death	Mental Hy	rgiene 2 () (8 10488
			Decedent's Name (First, Middle, Last,)				2. Date of De	eath	3. Time of Death
П	Physic		DARYI		YEN	TIS		Month MARC)		08 3:15 AM
1	/Medi Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Dea		4c. County of	
			THE JOHNS	HOOKINS HO	SPITA	BAIT	INDOF	CITY	11/	
	Funeral		5. Social Security Number 6. Sec			If Under 1 Year	If Under 24 Hrs		rth S	. Birthplace (State or Foreign
	Director		546-56-4734	^{KM 2□ F} 66	Yrs.	Months Days	Hours Min	Feb 20	1942	California
	P .		Usual Residence of Decedent						,	OGETTOTISE OF
	anyla	-	Districtof 10b. County	10c. City	, Town or Loca	ation				10d. Inside City Limits
	Sa-f	ct	Columbia N/A		Washi	ngton DO	3			1 X Yes 2 ☐ No
	in the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Who	at Country?
	23a	<u>a</u>	4457 Greenwich 1	Parkway N.W.		2000	7		USA	
	r de	ne	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?		as Decedent of H	ispanic Origin? (Specify Yes or No		American Indian, White, etc.
36	or l	Y.	1 Never Married 2 Married	1 □ Yes 2 █️No If Yes, Give		☐Yes 2☐XNo	Specify:	,	Specify:	White
21215-0036	filed within 72 hours after death with the Maryland Hygiene. sther then "neturel", or Iteme 23a or 28a-1 ehow ent, the Medical Examinar must be notified at	Completed by Funeral	3 Widowed 4 Divorced	Year or Dates:					0,000	MILLE
7	net rile	ete	15. Decedent's Edu (Specify only highest grade		(Give ki	nt's Usual Occup nd of work done o	during most of wo	orking	16b. Kind of Busin	ness/Industry
12	withir ane.	E	Elementary/Secondary (0-12)	College (1-4or 5+)		NOT use retired			Norra I Da	search Lab
7	Hygie ther nt.	ပိ	17. Father's Name (First, Middle, Last)	J	Asti	ro Physi		- /First Stindella	, Maiden Sumame)	search Lab
Maryland	ntal h	Be	Max Yentis							
Ž	hould d Me mark mark	ဥ		no (Print)	405 14-18-1				alsky	
Ma	d2s than 7 is i		19a. Informant's Name/Relationship (Ty) Judye Brown, Sis	•					er, City or Town, Sta	
	1 and Heeli em 2 ther		20a. Method of Disposition					erman Val		ornia 91423
פֿר	or o		1 ☐ Burial 2 【XCremation 3 ☐ R	emoval from State	metery, crema	ion (Name of tory or other plac	θ)	Date	20c. Location - Ci	
₫.	rtmer rtant njury		4 Donation 5 Other (Specify)	Met	ro Cren	natory I	nc.			e, Maryland
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heelth and Mental Hygiene. Important: If Item 27 is marked other then "neturel", or Iteme 23s or 28s-f ehow emportant: If Item 27 is marked other then "neturel", or Iteme 23s or 28s-f ehow only injury or other treumatic event, "its Medical Examinar must be notified at onc.		21. Signature of Funeral Service License Thomas Gregor	Thomas Buy	~~ ² Ci	emation 99 Frede	s Society rick Roa	/ Of Mary ad Baltin	yland, Ind more, Mary	viand 21228
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the death	Do not enter	the mode of dyin	g, such as cardia	c or respiratory a	rrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	SEPSIS						Onset and Death
	/Medical		resulting in death)	Due to (or as a consequent	ence of):					2 Days
	Examiner		Sequentially list conditions, b	CHRONIC	LYMP	HOCYTIC	LEUK	EMIA		
	₽ 12/ =	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequent	ence of):	7				
	ocute nd trans	am	that initiated events							
Ö,	e exe sien a urial-	ũ	resulting in death) Last	Due to (or as a conseque	ence of):					
8760,	death certificate be executed e attending physicien and id for use as the burial-transit	dical								
9	ing p	Mec	IF FEMALE:							
Вох	leath certific attending p	an/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal o	death 3 □E	ctopic pregnancy			23d. Date of Month	,
	at the de by the a tached f	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of dea 9☐Unknown	ath 5□C	other (specify)			Month	Day real
J.	d by detac	Ph	Part II. Other significant conditions con	taibution to double but not and	Alman in Abroson d			00 Div		
Records,	The law requires that the the has been signed by the age 2 should be detached.	l by	Tarrii. Ottor signineant conditions con	mounting to death but not resul	ung in the unde	errying cause give	en in Parti.			Ite to the cause of death?
Ö	requ hould	Completed						10	Yes 2 2No 3[Probably 4 Unknown
ec	e 2 s	du						24a. Was	osy prio	re autopsy findings available r to completion of cause of
		ပ္ပ						1 Yes	rmed? dea 2□No 1□	th? Yes 2□ No
Vital	ician: certifice rector, p	Be	25. Was case referred to medical examiner?					ath Check only	one)	
6	Phys this al dir	2	1 165 21700		R/Outpatient		4 Li Nursing r		dence 6 □Other ((Specify)
ב	ding I h. After funer	on	27. Manner of Death 1 → Autural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe	how injury occurred	
S	tend Jeath tor: the f	cat	2 Accident investigation 3 Suicide 6 Could not be				/es 2 □ No			
DIVISION	or Ai	Certification:	4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, streel	t, factory, office		281. Location (Street and Number (vn, State)	or Rural Route Number.
_	To the Hospitel or Attending Physicien: within 24 hours after deals. To the Funerel Director: After this certifica completely filled in by the funeral director,		29a. Certifier 1 Certifying Phys	iology To the base of	ladas (;					
	Fun Fun stely	Ilcai	(Check only 2 Medical Exemin	icien: To the best of my know er: On the basis of examination and manner stated.	ledge, death of on and/or inves	ccurred at the tim stigation, in my op	e, date and place pinion, death occu	e, and due to the urred at the time,	cause(s) and manne date and place, and	er as stated. I due to the cause(s)
	o the	Med	29b. Signature and title of certifier	and marker stated.		29c. License	number		29d. Date signed (A	Aonth Day Year)
)	- s + ŏ		NI	MENINA	4					
	D		30. Name and address of person who cor	MEDICAL D					MARCH 2	
	1		M. ILLILETTAL DESCRIPTION CON	mpleted cause of death (Item 2	A/	(III)	na 1-	0	F 41 + 0	
	Sta	te.	31. Date filed (Month, Day, Year)	2. Registrar's Signatu	/ V <i>07</i> 4 <u>77</u> 74	WOLFES	INCET, I	THUTIMOR	C, MARYLA	NO 21287
	Registra		APR 0 1 2008	2. Regisfrar's Signatu	Local	5.				

DHMH 17 Rev 1/2001

	02297 hele Theresa	Zel		pe or Print ir tate of Maryla	ind / Depa	artme	nt of	Health and				gible.	200	10	inlo
			1- For State Registrar		Cei	rtifica	te of	Death				g. No.	201		1048
Mo	Physicia dical Exami		Decedent's Name (First, Midd								Date of Deat Month	Day	Year	3. Time of 1249	
IVIE,	gical Exami	ner	Michele —— 4a. Facility Name (if not institution	11-11-11	eller		14	b. City, Town, or	l ocation of		March 23,		ounty of Dea		
J			2715 McComas Ave	on, give street and no	mber)			Dundalk	20001101101	Doda			timore Co		
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	ast birth	day)	If Under 1 Yea	r If Under	24Hrs. 8	. Date of Birt	h(MM/DD			ate or
	Director		213-68-8426	1_M 2XF	50		Yrs.	Months Day	Hours	Min.	08/01/	57	Fore	eign Sountry) M	D
		ŀ	Usual Residence of Decedent												
	v any		10a. State 10b. County MD Balt	imore	10c. City	Town o									de City Limits
	Maryland 28a-f show d at once	5				Dan									es 2 X No
	Mary - 28a-	Director	10e. Street and Number	7,770,70,110				10f. Zip Code	222		11		of What Co	untry?	
0	th the 23a on notifie		2715 McComas												51
2	ith wil	Funeral	11. Marital Status 1 Never Married 2 N	12. Was Dec	edent Ever in U prces?	.S.		Decedent of His es, specify Cubar				- 14	. Race - Am White, etc.	erican Indian	, Black,
4	er dea			1 Yes	2X No		1	Yes 2 X No	s necify:			Sr	ec <i>ify:</i> Whi	+6	
/	urs aft tural*	by	15. Decedent's Education (Spe	or Dates:			ecedent	's Usual Occupa	tion (Give k				d of Busines		
	72 hor "na al Ex	etec	Elementary/Secondary (0-12)) College (1	-4 or 5+)	d	-	ost of working life	. DO NOT (use retired)	T. C	Dog+-	al Ser	*** 00
	5-0036 led within 7 Hygiene. other than	Completed	12				Sec	retary						ıı ser	vice
	5-0 iled w Hygic I othe		17. Father's Name (First, Middle Robert T.	e, Last) Zeller							rst, Middle, I				
	2121 ould be fil Mental I marked c event,	Be				404	M-00-	Address (O)		Doris		McCu		to Tin Code	
Joseph P. Stahl/ Companion 2715 McComas Avenue Dundalk, Maryland 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or															
	Ore ges 1 t of H i: If i		1 Burial 2 Crematic	n 3 Removal fr	UIII State		•	er place)	, l	2 /20	/ 0.0			Marri	and
	Baltimore, permit. Pages I an Department of Her Important: If ite night or other the night of the permits of the night of the the the permits of the permits		4 Donation 5 Other S 21. Signature of Funeral Service	and the same of th	H	LIIto	op S	ervice dame and Addres	orp.	Duda	/08 -Ruck			Maryl Indalk	
	Ba perm Depa Imp		The state of the s	Z a	,			22 Wise							
	Physician		23a. Part I. Enter the disease, of	r complications that c		n. Do not								Approx	imate Interval en Onset and
1	Ledical		failure. List only one cause Immediate Cause (Final diseas)	14.1.1.1	Drug Int	oxica	ation							Betwee	Death
1	taminer		or condition resulting in death)		consequence										
		_	Sequentially list conditions,	b										-	
		xaminer	if any, leading to immediate course. Enter Underlying Course		consequence of	01):									
	=	хап	(Disease or injury that initiated events resulting in death) Last		consequence of	of):									
	executed an and al - trans	ш		d					070 /	/10 /00	<u> </u>				
	be ex sician urial	ğ	X UNPENDED	AMENDED	1,23a,Pt.	Π ,2	/,28a	-f per ME	g 8/8 4	i/10/0	3 amh 		_		
	n of Vital Records, P.O. Box 68760, ling Physician: The law requires that the death certificate be execute. After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - tran	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in		outcome of preg		- Fe	tal death 3	Ectopic	pregnanc	v		Date of deliv Ionth	ery Day	Year
	x 68 h certi tendin use as	cia	past 12 months?	4 Pregr	nant at time of d	eath 5		ner (Specify)	Lotopic	programo	,	"		,	
	Bo; e death the att	hysi	1 Yes 2 No 9 🗸 Ur	nknown g Unkn	own			5-5							
	P.O.	by P	Part II. Other significant cond	•		_	in the u	nderlying cause	given in Pa	rt I.				to the cause	of death? Unknown
	S, P	De la	Atherosclerotic	Cardiovascu	lar Disea	se									
	ord: w requisited shoul	olet									24a. Was autor	osy	prior t	o completion	dings available of cause of
	Pec The la	Completed									1 Y Yes	rmed? 2 No	death 1		2 No
	of Vital Records, ng Physician: The law requir wher this certificate has been sineral director, page 2 should b	a)	25. Was case referred to medic examiner?					26.Plac	of Death	Check on	y one)				
	Vit hysic this c	To B	1 ✓ Yes 2 No		Inpatient 2		tpatient		Other ₄	Nursing I			ce 6 🗸 Ot	her: Scene	
	Ing P		27. Manner of Death 1 Natural 5 Death		of Injury n, Day,Year)		ime of I		ıryat Work Yes 2 Ϊ		3d. Describe	how injury	occurred /		
	ivisior or Attencather death Director:	catio		estigation Fnd 3/			12:4	Up		U	nk	Ctroot on	A Number or	Bural Bouto	Number, City
	Division tal or Attendir rs after death.	ertification:	det	uid not be		iome, tai	ım, stree	et, factory, office	ouliuing, et		or Town . 715 McC				
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	O	29a. Certifier	Physician: To the be	House	doo doo	th occur	red at the time of	ate and nic						,
	the H hin 24 the F	Medical	(Check only Certifying i	aminer:On the basis	of examination	and/or in	vestigat	ion, in my opinio	n, death oc	curred at the	ne time, date	and place	e, and due to	the cause(s	s)
	To To con	Mec	29b. Signature and title of certif	and manner s	stated.			29c. Licen:						Month, Day,	
-	. Au	1.0	\wedge \rightarrow	6				1 00	N 4 🗆			1 14	h 24 200	0	

State

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ana Rubio MD.

APR 0 1 2008

31. Date filed (Month, Day, Year)

ORIGINAL

O.C.M.E.

March 24, 2008

Registrar

			For State Registrar	State of Ma			ent of H	ealth and M	Mental Hyg		008	10	190
			1. Decedent's Name (First, Middle, La	st)					2. Date of Dea Month	th Day	Year	3. Time of	Death
	Physic		John V	illiam Bur	kman, S	r.			March	14, 2	008	6:11	p M
	/Medi Examir		4a. Facility Name (If not institution, giv	e street and number)		4b. 0	City, Town, or	Location of Death		4c. Cour	nty of Death		
1		•	376 Old Mill F	Road			Cor	nowingo			Ceci	1	
	Funeral		5. Social Security Number 6. S		e (In yrs. last bir	thday) If Ur Mon	nder 1 Year ths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey	Year)	9. Birthp	lace (State of	or Foreign
	Director		216-52-1178	IM 2□F	59	Yrs.	uis Days	riouis iviai.	Oct. 1,	1948	M	arylar	nd
	P		Usual Residence of Decedent		40- Oh. T	!*:					-	0d. Inside C	its Limite
	aryla ehov	-	10a. State 10b. County		10c. City, Tow	n or Location					1		2 ⊠ No
	86-1	cto	Maryland Cec	il				wingo					
	or 2	100	10e. Street and Number	1/		10f.	. Zip Code	0.0	1	0g. Citizen o	itizen of What Country? U.S.A.		
	deeth with the Maryland me 23a or 28e-f show Imissi be notified at	by Funeral Director	376 Old Mill Roa					.918	N	14.5	14. Race - Americ		
	er de	une	11. Marital Status	12. Was Decedent Armed Forces?		13. Was Di						etc.	
36	s eft	γF	1 ☐ Never Mamied 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 XYes 2 ☐ ! If Yes, Give Year or Dates:		1 ☐ Ye	s 2 🔀 No	Specify:		Spe	city: V	Nhite	
9	hour fure		15. Decedent's E	1		Decedent's	I leval Occups	ation		16h Kind of	Business/In	dustry	
1 2	n 72	olet	(Specify only highest gra	ade completed)		(Give kind o	f work done of	during most of wor	king]		hem St		
21215-0036	with ene.	Completed	Elementary/Secondary (0-12) Twelve Years	College (1-4or 5	i+)		Forem	an		Baltim	ore, N	Maryla	nd
	filed Hyg other	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle,	Maiden Sum	ame)		
an	ld be enta ked c ev	To B	Louis Wil:	liam Burkm	an, Sr.			The	eresa Dei	lores	Murphy	7	
Maryland	shound M	_	19a. Informant's Name/Relationship (Type, Print)	196	. Mailing Add	ress (Street a	and Number or Ru	ral Route Number	r, City or Tov	vn, State, Zip	Code)	
	nd 2		John W. Burkman,	Jr. (son) 5	Shore	nam Co	urt, Not	cingham,	Maryl	and 2	21236	
e,	s 1 e		20a. Method of Disposition		20b. Place of	Disposition	(Name of or other place	e)	Date	20c. Locatio	on - City or To	wn, State	
) E	Page sent c nt: If ry or		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special			y crematory Laney Va orial G		03/	/20/08	Fimoni	um, Ma	rylan	d
Baltimore,	permit. Pages 1 end 2 should be filed within 72 hours efter deeth with the Marylan Depertment of Heelth and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Iteme 23a or 28e-1 show any Injury or other treumatic event, the Mudical Examinat must be notified at once.		21. Signature of Funeral Service Lice	nsee		22. Nam	e and Addres	s of Facility	Con Franci	1 77	iomo T) 7	
m	Depermine Deperm		Shon Eas I No	10000	in de			terson & , Marylar				· A ·	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused					Approxima Interval Be	tween			
4	Physician		Immediate Cause (Final disease or condition ESOPheral Cancer										Death
	/Medical		resulting in death)	Due to (or as	a consequence	of):		~	(
)	Examiner			b	1	0							
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence	of):							
	The law requires that the death certificate be executed ate has been signed by the ettending physicien end page 2 should be detached for use as the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C									
760,	e exe ien ei irial-t		resulting in death) Last	Due to (or as	a consequence	of):							,
376	ate be nysica he bu	cal	•	d									
89	eath certificate ettending phys I for use as the	Physician/Medi	IF FEMALE:										
Вох	th ce tendi	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	of pregnancy 2 Fetal death	3 □Ectop	ic pregnancy			1	Date of delive	-	Year
	ed for	SICI	1 ☐ Yes 2 ☐ No	4□Pregnant at 9□Unknown	time of death	5 🗌 Other	r (specify)				NO THE	July	· oui
P.0	d by i	Ph	9 Unknown					- 1- D- 44	02a Didaa	bassa	ontribute to t	ha sauca of	doath?
	res that the de signed by the e I be detached f	by	Part II. Other significant conditions	contributing to death b	ut not resulting ii	the undertyl	ng cause give	en in Parti.	230. Did to	~/			Unknown
of Vital Records,	w require been si should	Completed							101	95 2/2014C	, 3 1100	Jaciy 4	O I KI I O WI
eC	e law has b	ple							24a. Was a autops	sy		psy findings mpletion of (available cause of
<u> </u>	The I	5							perfor 1 ☐ Yes	med? 2 No	death? 1 ☐ Yes	2 No	
/ita	ilcien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?						th (Check only or	ne)			
_	Physic this o	ပ္	1 Yes 2 No		nt 2□ER/Ou	tpatient 3	DOA Othe	4 Nursing H			Other (Specia	(y)	
٦	ding P h. After t funera	0	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry Year) 28b.	Time of njury	28c. Injury Work		28d. Describe h	ow injury occ	curred		
Sio	tend leath tor: /	cat	2 Accident investigation 3 Suicide 6 Could not b			М		Yes 2 □ No	004 1 2 2 2 40			10 1/	
Division	t or Attendi efter death. Director: A	Certification:	4 Homicide determined	28e. Place of Injuding, et	ury - At home, fa c. <i>(Specify)</i>	rm, street, fa	ctory, office		28f. Location (S City or Tow		imber or Huri	ai Houte Nun	noer,
	To the Hospital or Attanding Physicien: within 24 hours effer death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Ce	00- C-48 Maria		-6	4-5-4						tota d	
	To the Hospital within 24 hours e To the Funerel Completely filled	edical	29a. Certifier (Check only one) Certifying Pl	nysician: To the best miner: On the basis of and manner sta	examination an	dor investiga	rred at the tim ition, in my op	ne, date and place pinion, death occu	, and due to the d rred at the time, d	ause(s) and late and plac	manner as s ce, and due to	the cause	s)
	thin (Med	29b. Signature and title of certifier	and manner sta	iteU.		29c. License	number		29d. Date sig	hed (Monti	Dey, Year)	
	13 T 8					INT	F 7	TOSL	JUa	2	1,01	PA	
,	11.					V	· •	100	1771	_2(. //	φ	2192
,	HVA		20. Name and address of person who	completed cause of d		ype, Print)	1 Ha	6519	5+	6 2n	2 [Kton	MI
	Sta	te	31. Date filed (Month, Day, Year)	7/32. Registr	ar's Signature	100	J. /4/	7.01.	Jul 19			TIM	1
	Registr		MAD 1 9 2008	Kanha	K A	and I							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year Matthew Herman BORING 20 2008 /Medical March 0521 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Washington

9. Birthplace (State or Foreign Country) Hagerstown 8. Date of Birth (Month, Day, Year) If Under 1 5. Social Security Number Age (In yrs. last birthday) **Funeral №** M 2□ F Months Hours 74 Director 214**-**34-0342 April 22 1933 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at Director 1 ☐ Yes 2X No Washington Maryland Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 105 Valley View Court Completed by Funeral 21713 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 【X Married 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 🎇 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Practicing Veterinarian Elementary/Secondary (0-12) College (1-4or 5+) & Dept. of Agriculture 0 - 12Veterinarian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ٩ Matthew Luther Henry Roring Lillian Ruth Stamm 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marilyn Boring - Wife 105 Valley View Court, Boonsboro, Maryland 21713
of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition p. rmit. Pages 1 Department of H Important: If ite any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Weller U.M.Church Cem. 3/24/08 Thurmont, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home Approximate Interval Between onset and Death 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Physician/Medical as the l 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9 I Inknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? certificate perform 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 □ №ОА ပ 1 ☐ Yes 2 ER/Outpatient After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 □ No 2 Accident Director: 3 ☐ Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To unce within 24 hours anter To the Funeral Dir To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Descripting Physician To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature NIO 0. Name and a rson who completed cause of death (Item 23a) (Type, Print) 00H-7 2120 21783 31. Date filed (Me sistrar's Signature State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760

			1 - For State Registrar	State	of Maryla		artmer <i>rtifica</i> i				lental H	ygien Reg. No		8	A STATE OF THE STA	92
	Physici	an	1. Decedent's Name (First, Midd	lle, Last)							2. Date of E			ear	3. Time of	Death
	/Medi		JoAnn	Bryan							March		2008	oai	1:50	АМ
	Examir	ier	4a. Facility Name (If not institution		number)		4b. City,	, Town, or	Location of	of Death		40	. County of I	Death		
			100 Third Stre	+	7 4 //	to a definite do a		erste		O A Hea		Washir				
	Funeral Director		220-42-7469	6. Sex 1 ☐ M 2)X		i. last birthday) X Yrs.	Months		If Under:	Min.	8. Date of B	Day, Year,	,	Coun	lace (State of	or Foreign
			Usual Residence of Decedent		0.			Ll			Nov. 2	7, 1	944 Ma	ar y 1	and	
	rylan how		10a. State 10b. Count	1	10c. C	ity, Town or Lo	ocation							1	0d. Inside C	ity Limits
	e Ma	cto	Maryland Washi	ngton	Ha	agersto	wn								1 X Yes	2 □ No
	ith th	Oire	10e. Street and Number				10f. Zip	Code				10g. Ci	tizen of Wha	at Coun	try?	
	ath w	ā	100 Third Stre				2	21740					USA			
	er de	nue	11. Marital Status	Armed	Decedent Ever in I 1 Forces?	U.S. 13.	Was Dece If Yes, spe	dent of His cify Cubar	spanic Oriç 1, Mexican	gin? (Spe ı, Puerto i	cify Yes or N Rican, etc.)	lo-	14. Race - American Indian, Black, White, etc. Specify: White			
39	irs aft	by Funeral Director	1 ☐ Never Married 2 ☐ Mai 3 ☐ Widowed 4 ☐ Divorce	If Yes,	es 2 No Give or Dates:		1 🗆 Yes	2 X No	Specify:							
Maryland 21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Medical Examinating to invitited at			nt's Education	-	16a. Dece	dent's Usual Occupation					16b. K				
2	hin 7 9. Medi	Completed	(Specify onfy higher Elementary/Secondary (0-12)		e (1-4or 5+)	(Give	kind of wo DO NOT u	ork done d ise retired)	uring most	t of workii	ng		16b. Kind of Business/Industry			
7	er th	Con	9	355		House	ewife				Home					
nd	be file tal Hy d oth avant	Be	17. Father's Name (First, Middle	Last)					18. Mothe	r's Name	(First, Middl	e, Maider	Sumame)			
<u>\}</u>	ould Men narke	P	Leslie Clemens								ene Ha					
ā	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hyglene. If item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic avant, the Medical Exam and or unities at		19a. Informant's Name/Relations	, , , , ,							Route Num			te, Zip	Code)	
e,	1 and Healt em 2 thar t		James R. Bryan	- Husba		Place of Dispo		-	et H	-	stown,			Ta	Charle	
ltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or othar once.		1 X Burial 2 ☐ Cremation		om State	cemetery, crei	natory`or o	other place					ocation - City			
	artme ortani injury		' 4 □ Donation 5 □ Other (S	1/1/14	/ Gr	een law	n Mem	oria	l Park	3-2	21-2008	Wil	liams	por	t,Mary	land
Ba	permi Depa Impo any i		V . 1	7 V							orne F e St.					705
			23a. Part1. Enter the disease, o	r complications th	at caused the dea								ramspc	л ,	Approximat	te
	Physician	ŧ V	shock, or heart ailure. Lis Immediate Cause (Final		ONIC	OBSTR	V C 711	/F /	PULA	DONIF	12V	X10	FASE		Interval Bet Onset and I	Death
	/Medical		disease or condition resulting in death)	a	to (or as a conse		1611	/ _ /		,,,,,,,			-/		UNK N	ICUN
	Examiner		Commentally lies and distance	b												
	P #	ner	Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury		to (or as a cones-	quer ce oty.										
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c												
20	ate be executed hysician and the burial-transit		resulting in deatil) cast	Due	to (or as a consec	quence of):										
8760	ate hy the	dicai		d										+		
×	The law requires that the death certification in the has been signed by the attending places 2 should be detached for use as to	Physician/Med	IF FEMALE:	23c. If yes	outcome of pregn	ancy			-93							-
Box	atten I for u	cian	23b. Was decedent pregnant in the past 12 months?	1 Liv	re birth 2 Fet	aldeath 3□	Ectopic pr Other <i>(sp</i>					1	23d. Date of Month		•	Year
o.	at the de by the a tached	ıysi	1 ☐ Yes 2 XNo 9 ☐ Unknown		known		2 0 11101 (0)	,oo,,y,								
J.	w requires that been signed b should be deta		Part II. Dther significant conditi	ons contributing to	death but not re	sulting in the u	nderlying c	ause giver	n in Part I.		23e. Did	tobacco	use contribut	te to th	e cause of d	leath?
<u>5</u>	quire n sig uld b	Completed by	ATRIAL	FIBRIL	LATION	J					12	Yes 2	□ No 3□	Proba	ably 4 🗀	Jnknown
ပ္တ	s bee	plet									24a. Wa		24b. Were	e autop	sy findings	available
Ĭ	: The law cate has page 2 s	Eo										ormed?	deat	h?	npletion of ca 2 X No	ause of
Vital Hecords,	ician: Th certificate rector, pag	Be C	25. Was case referred to medica						26. Place	of Death	1 Yes	2 No one)	,	103	ZA NO	
01 <	Physician: this certific ral director,	Tof	examiner? 1 ☐ Yes 2 No	Hospital: 1	□ Inpatient 2 □	ER/Outpatien	t 3 🗆 DC	Other	~ 4 □ Nur	sing Hom	ne 5 Res	idence	6 ☐ Other (S	Specify)	
	ding P h, After ti funera		27. Manner of Death 1 ★Natural 5 □ Pendir		te of Injury fonth, Day Year)	28b. Time of Injury	2	8c. Injury	at ?		8d. Describe					
<u> </u>	Attanding or death. actor: After by the fune	cati	2 Accident investi	gation			М		es 2□N	io						
DIVISION	I or Attano after death Diractor: I in by the	Certification:	4 Homicide determ	ined 286. Pla	ace of Injury - At h ilding, etc. <i>(Speci</i>	iome, farm, stre fy)	et, factory	, office		2	8f. Location City or To			r Rural	Route Num	ber,
_	pital ours a eral (29a, Certifier 1 Certifyir	a Physician, Ta	Abo b - 4 -6 1											
	24 hc 24 hc Fun etely	edicai	(Check only 2 Medical one)	g Physician: To Examiner: On the	the best of my kno basis of examina anner stated.	owledge, death ation and/or inv	estigation,	at the time , in my opi	e, date and nion, death	i place, a h occurre	nd due to the d at the time	cause(s) , date and	and manne d place, and	r as sta due to	ited. the cause(s))
	To the Hospital or A within 24 hours after To the Funeral Dirac completely filled in by	Me	29b. Signature and title of certifie				290	. License	number			29d. Dat	te signed (M	Ionth. D	ay, Year)	
	L>F0		Homah		Ms.			58	181			MAR		18	200	8
			30. Name and address of person			m 23a) (Type. i			0/			7. 1. 1	~ /	0		-
9	4-3		KODUAH PEPR	AH :	324 E A			# 3	306	HAG	ERSTON	No	MD	2	1740	
	Sta	te	31. Date filed (Month, Day, Year)	2000 32	. Pagistrar's Signa	ature	1	V.								
8.	Registra	ar	MWW T 2	2008	A Photosomer	15 1		9								

	Registrar				Ce	artment o	of Deatl	h		Reg. No.	200	8	10	+9
an	1. Decedent's Name (First, M	Aiddle, La	ast)						Date of Do Month	eath Day	· V	'ear	3. Time o	f Death
cal	Isaac Brown	n,	Jr.						March				8:10	p
	4a. Facility Name (If not instit	tution, giv	ve street and nu	umber)		4b. City, To	wn, or Location	of Death		4c.	County of	Death		
	Montgomery			+		Olne					Mont	gome	ry	
	5. Social Security Number $411 - 07 - 1818$		Sex 1.23xM 2F	7. Age (In yr.	s. last birthday) Yrs.	Months D			8. Date of Bi (Month, Di)ec. 10	ay, Year)		Birthpla Countr enne		or Fon
	Usual Residence of Deceden			140- 6	No. Tours of							1		
_	10a. State 10b. Co	unty		100.0	City, Town or Lo	ocation						100	l. Inside C 1 □ Yes	-
45 1	Maryland	M	on tgome	ry	Sil	ver Spi								۷.۵.
ä	10e. Street and Number					10f. Zip Co				U	zen of Wh	at Countr	y?	
eral	3701 Inter	nati				W DI	20906		" \	U.S		A	Indian	
Funeral	11. Marital Status 1 ☐ Never Married 2 ☐	Marriad	Armed F	cedent Ever in forces?	0.5.	Was Deceden If Yes, specify	Cuban, Mexic	an, Puerto	Rican, etc.)	0-	14. Race - Black,	White, et		
by	3 → Widowed 4 □ Divo		If Yes, G	iive	wwii	1 ☐ Yes 2 🗔	₹No <i>Specif</i>	y:			Specify:	Blac	c C	
be		edent's E		- 4.00.		dent's Usual C	Occupation			16b Kir	nd of Buşir	nass/Indu	etny	
Completed	(Specify only hi	ighest gr	ade completed,		I (Give	kind of work of DO NOT use r	done durina ma	ost of worki	ing		114 01 04011	nego, mad	oay	
E O	Elementary/Secondary (0-1	12)	College ((1-4or 5+)	Acc	countar	nt			Depa	artme	nt o	f the	Na
Be C	17. Father's Name (First, Mic	ddle, Lasi	1)				T	her's Name	(First, Middle					
To B	Isaac Brown						1 1	Hatti	e	Bradl	ev			
-	19a. Informant's Name/Relat	tionship ((Type. Print)		19b. Mailii	ng Address (S.	treet and Num	ber or Rura				ate, Zip C	ode)	
	Bobbie Knable	e/Da	ughter			Mason I								
	20a. Method of Disposition	-		20b.	Place of Dispo	osition (Name	of		ate	20c. Loc	cation - Ci	ty or Tow	n, State	
	1 ☐ Burial 2 🖾 Cremati 4 ☐ Donation 5 ☐ Othe				tropoli	matorý or othe i tan Cr	· · · · · · · · · · · · · · · · · · ·	, Ma	rch 19	, ₂ -	lexan	dria	Wir	air
-	21. Signature of Funeral Sen					2. Name and A			2008	111	ICACII		, , , , , ,	9
	Immediate Cause (Final disease or condition resulting in death)	List only	a. A	each line.	leroti	ter the mode o	f dying, such a	as cardiac c		arrest,		1	Approxima nterval Be Onset and	te tween Death
Exal	Immediate Cause (Final disease or condition		a. Due to	herosc	dero hi	ter the mode o	f dying, such a	as cardiac c	or respiratory a	arrest,		1	nterval Be Onset and	te tween Death
dical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	{	a. Al Due to b. Due to c. Due to d	or as a consection of the cons	equence of): equence of): equence of): equence of):	ter the mode o	f dying, such a	as cardiac c	or respiratory a	arrest,	23d. Date o	of delivery	nterval Be Onset and Clark	te tween Death
Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	{	a. All Due to b. Due to c. Due to d	cor as a consecution of the correction of the consecution as a consecution as a consecution of the correction of the cor	equence of): equence of): equence of): equence of): equence of):	ter the mode o	f dying, such a	as cardiac c	Prespiratory a	arrest,	23d. Date o	of delivery	nterval Bed Onset and Clark A Duy	te tween Death
by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	t diditions of	a. All Due to b. Due to c. Due to d	each line. Y OSC (or as a consector of consector of sector of consector quence of): equence of): equence of): equence of): equence of):	ter the mode o	f dying, such a	as cardiac c	ar respiratory a	tobacco us	23d. Date o Month	of delivery	riterval Beonset and Cylar R. Comments and Cylar R. Cylar	te tween Death Year	
by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	t diditions of	a. Due to b. Due to c. Due to d. 23c. If yes, out 1 Live 4 Preg 9 Unkr	each line. Y OSC (or as a consector of consector of sector of consector quence of): equence of): equence of): equence of): equence of):	ter the mode o	f dying, such a	as cardiac c	23e. Did	tobacco us	23d. Date of Month	of deliveryn Dute to the	ay cause of only	te tween Death	
by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	t diditions of	a. Due to b. Due to c. Due to d. 23c. If yes, out 1 Live 4 Preg 9 Unkr	each line. Y OSC (or as a consector of consector of sector of consector quence of): equence of): equence of): equence of): equence of):	ter the mode o	f dying, such a	as cardiac c	23e. Did	tobacco us Yes 2	23d. Date of Month se contribu	of delivery	riterval Beonset and Cylar R. Comments and Cylar R. Cylar	Year Year Unknow availa	
Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	additions of	a. Due to b. Due to c. Due to d. 23c. If yes, out 1 Live 4 Preg 9 Unkr	each line. Y OSC (or as a consector of consector of sector of consector quence of): equence of): equence of): equence of): equence of):	ter the mode o	nancy e given in Part	as cardiac c	23e. Did 1 □ 24a. Was auto perf. 1 □ Yes	tobacco us Yes 2 an an posy 2 2 No	23d. Date of Month se contribu	of delivery	riterval Beofre	Year Year Unknow availa	
Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	additions of	a. Al Due to b. Due to c. Due to d. 23c. If yes, ou 1 Live 4 Preg 9 Unkr	each line. Y OSC (or as a consecto	equence of): equen	□Ectopic pregr □ Other (special	nancy e given in Part	as cardiac c	23e. Did 1 □ 24a. Was auto perf. 1 □ Yes	tobacco us Yes 2[san upsy ormed2 2] No one)	23d. Date of Month se contribu No 3 24b. We price dec 1 [of deliveryn Dute to the Probalere autoppor to compath?	ay cause of only indings oletion of ole	te tween Death S
To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	additions of	a. Al Due to b. Due to c. Due to d	each line. YOSC (or as a consector	equence of): equen	□Ectopic pregr □ Other (special nderlying caus	nancy e given in Part 26. Plac Other: 4 N	as cardiac c	23e. Did 1 □ 24a. Was auto perf. 1 □ Yes. 1 (Check only)	tobacco us Yes 2 s an ppsy ormed2 2 No one) idence 6	23d. Date of Month se contribu No 3 24b. We price des 1 6 Other	of delivery Dute to the Probal Probal Probal Probal Probal Probal (Specify)	ay cause of only indings oletion of ole	te tween Death S
To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Secuentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant con Acuse. Ren 25. Was case referred to medexaminer? 1 Yes 2 No 27. Manner of Death 1 Watural 5 Per	dical anding	a. Al Due to b. Due to c. Due to d. 23c. If yes, ou 1 Live 4 Preg 9 Unkr	each line. YOSC (or as a consector	equence of): equen	□Ectopic pregr □ Other (special and and and and and and and and and and	nancy e given in Part 26. Plac Other: Injury at Work?	as cardiac of Culd (a)	23e. Did 1 □ 24a. Was auto perf. 1 □ Yes	tobacco us Yes 2 s an ppsy ormed2 2 No one) idence 6	23d. Date of Month se contribu No 3 24b. We price des 1 6 Other	of delivery Dute to the Probal Probal Probal Probal Probal Probal (Specify)	ay cause of only indings oletion of ole	te tween Death S
To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	dical dical dical	a. Al Due to b. Due to c. Due to d	acon line. (or as a consector of a consector of a consector	equence of): requence of):	□Ectopic pregr □ Other (special nderlying cause	nancy fy) e given in Part 26. Plac Other: Unjury at Work? 1 Yes 2	as cardiac co	23e. Did 1 24a. Was auto perf. 1 Yes 1 (Check only me 5 Res 28d. Describe	tobacco us Yes 2 s an psy ormed2 2 No one) idence 6 how injury	23d. Date of Month se contribution in No 3 and Month 24b. We print determine the Month of Mon	of deliveryn Dute to the Probalere autopsor to compath?	cause of obly 4 ay findings eletion of o	Year Year Unkno availal auuse
To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	dical ending restigation	a. Al Due to b. Due to c. Due to d. 23c. If yes, ou 1 Live 4 Preg 9 Unkr contributing to co Fail W Hospital: 1 28a. Date (Morne	acon line. (or as a consector of a consector of a consector	equence of): eq	□Ectopic pregr □ Other (special nderlying cause	nancy fy) e given in Part 26. Plac Other: Unjury at Work? 1 Yes 2	as cardiac co	23e. Did 1 □ 24a. Was auto perfi 1 □ Yes 1 (Check only) me 5 □ Res 28d. Describe	tobacco us Yes 2 s an psy ormed2 2 No one) idence 6 how injury	23d. Date of Month se contribution in the Month 24b. We print dec 1 C	of deliveryn Dute to the Probalere autopsor to compath?	cause of obly 4 ay findings eletion of o	Year Year Unknoc availa
Certification: To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Secuentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant con Acuse. Ren 25. Was case referred to medexaminer? 1 Yes 2 No 27. Manner of Death 1 Valural Female Female Female Female 29a. Certifier 1 Certifier 29a. Certifier 1 Certifier 29a. Certifier 1 Certifier 29a. Certifier 1 Certifier 29a. Certifier 1 Certifier 29a. Certifier 1 Certifier 29a. Certifier 1 Certifier 29a. Certifier 1 Certifier 25a. Certifier 1 Certifier 25a. Certifier 1 Certifier 25a. Certifier 1 Certifier 25a. Certifier 1 Certifier 25a. Certifier 1 Certifier 25a. Certifier 1 Certifier 25a. Certifier 1 Certifier 25a. Certifier 1 Certifier 25a. Certifier 25a. Certifier 1 Certifier 25a. Certifier 1 Certifier 25a. Certifier 1 Certifier 25a. Certifier 1 Certifier 25a. Certifier 1 Certifier 25a. Certifier 25a. Certifier 1 Certifier 25a. Certi	dical dical	a. Alabu Due to b. Due to c. Due to d. 23c. If yes, ou 1 Live 4 Preg 9 Unkr contributing to co Fail W Hospital: 1 28a. Date (Morneysiclan: To the build invested in the	death line. (or as a consector of a consector of as a consector of as a consector of as a consector of a co	equence of): requence Ectopic pregr Other (special and all all all all all all all all all al	nancy fy) e given in Part Cher: Unjury at Work? 1 Yes 2 fiffice	as cardiac c	23e. Did 1 24a. Was auto perf. 1 Yes 1 (Check only me 5 Res 28d. Describe	tobacco us Yes 2 san psy ormed2 2 No one) idence 6 how injury (Street and wm, State)	23d. Date of Month see contributions of No. 3. 24b. We print determine the print dete	of delivery Dute to the Probal Probal Pres autopsor to compath? Yes 2 (Specify)	cause of obly 4 ay findings eletion of o	Year Year Unknoc availa: ause	
ledical Certification: To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant con Ren Yes 2 No 25. Was case referred to medexaminer? 1 Yes 2 No 27. Manner of Death 1 Yes 2 No 28 Accident 1 Yes 2 No 29 Accident 1 Yes 2 No 29 Accident 1 Yes 2 No 29 Signature and title of certain the condition of the con	dical dical dical dical dical dical dical dical dical dical dical examined diffying Phical Examinifier	a. Alabu Due to b. Due to c. Due to d	acon line. (or as a consector of sector of se	equence of): eq	□Ectopic pregr □ Other (special nderlying cause nderlying nderlying cause nderlying	nancy fy) 26. Plac Other: 4 Nork? 1 Yes 2 C ffice he time, date a my opinion, do	as cardiac of Culdar	23e. Did 1 □ 24a. Was auto perf. 1 □ Yes 1 (Check only me 5 □ Res 28d. Describe 28f. Location (City or To	tobacco us Yes 2 san ppsy one) idence 6 how injury (Street and wm, State) e cause(s) , date and	23d. Date of Month se contribution of No. 3. 24b. We price determined of Number of Num	of delivery to the Probal ere autops or to compath? If yes 2 (Specify) If or Rural if the autops of the probal of the probal of the probal of the probal of the probability of the proba	cause of only ay findings oletion of o	Year Year Unkno availa availa ause
ledical Certification: To Be Completed by Physician/Medical	Immediate Cause (Final disease or condition resulting in death) Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant con Ren Yes 2 No 25. Was case referred to medexaminer? 1 Yes 2 No 27. Manner of Death 1 Yes 2 No 28 Accident 1 Yes 2 No 29 Accident 1 Yes 2 No 29 Accident 1 Yes 2 No 29 Signature and title of certain the condition of the con	dical dical dical dical dical dical dical dical dical dical dical examined diffying Phical Examinifier	a. Alabu Due to b. Due to c. Due to d. 23c. If yes, ou 1 Live 4 Preg 9 Unkr contributing to co Fail W Hospital: 1 28a. Date (Morneysiclan: To the build invested in the	acon line. (or as a consector of sector of se	equence of): eq	Ectopic pregr Other (special and a special a	nancy fy) 26. Plac Other: 4 Nork? 1 Yes 2 C ffice he time, date a my opinion, do	as cardiac of Culdar	23e. Did 1 □ 24a. Was auto perf. 1 □ Yes 1 (Check only me 5 □ Res 28d. Describe 28f. Location (City or To	tobacco us Yes 2 san ppsy one) idence 6 how injury (Street and wm, State) e cause(s) , date and	23d. Date of Month se contribution of No. 3. 24b. We price determined of Number of Num	of delivery to the Probal ere autops or to compath? If yes 2 (Specify) If or Rural if the autops of the probal of the probal of the probal of the probal of the probability of the proba	cause of only ay findings oletion of o	Year Year Availa availa availa availa

State Registrar

MAR 1 8 2008

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

			1 - For State Registrar	State of Many		epartment o Certificate d			jiene eg. No.2 () ()	8 10494			
	Physici /Medic		Decedent's Name (First, Middle, Last) CHARLES	E. BISHO	DΡ			2. Date of Dea Month MARCH	12, 200				
	Examir Funeral	er	4a. Facility Name (If not institution, give with Washington Adv 5. Social Security Number 6. Sec	ventist Ho	ospita n yrs. last birtho	1 If Under 1 Yo		Park		of Death IGOMERY 9. Birthplace (State or Foreign Country)			
	Director		219-34-7567 Usual Residence of Decedent 10a. State 10b. County]M 2□F	73 Yrs	5.	ays Hours M	in. (Month, Day Oct.1	0,1934	Maryland 10d. Inside City Limits			
	the Maryl, r 28a-f sho	Director	MD Montgom 10e. Street and Number			lver Sp:		1	Og. Citizen of W	1 Tyyes 2 □ No			
036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be rediffed at or other traumatic.	by Funeral	816 Easley St 11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Types 2 No If Yes, Give Year or Dates: 5 1	r in U.S.			(Specify Yes or No- erto Rican, etc.)	U.S.A. 14. Race - American Indian, Black, White, etc. Specify: Black				
121215-0036	filed within 72 hou Hygiene. other then "netura ent, the Medical E	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 8th 17. Father's Name (First, Middle, Last)	cation	vorking		nore Ding Center						
Maryland	2 should be filed v and Mental Hygie Is marked other t raumatic evant, III	To Be	John Bishop 19a. Informant's Name/Relationship (Ty.)	na Printi	10h M	siling Address (St	Eli	lame (First, Middle, I zabeth V Rural Route Number	Withers	5			
	jes 1 and 2 s of Health an of itam 27 ls or other trau		Frances Bishop 20a. Method of Disposition 1 Burjay 2 Cremation 3 R	(Wife)	816		y St, #5	23,Silve	er Spri	ing, MD 20910 City or Town, State			
Baltimore,	permit. Pages 1 an Department of Heal Important: If itam 2 any injury or other ance.		4 Denation 5 Other (Specify) 21. Signature of Funeral Service License	FUNERA	AL HOME, P.A. Le,MD 20850								
	Physician /Medical	8	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	SIOPU	More	dying, such as card	iac or respiratory arm	est,	Approximate Interval Between Onset and Death			
8760,	executed	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of):	AL IN	ed ble	en Eolreg					
.O. Box 6	that the death certific ed by the attending p detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death	3 Ectopic pregna 5 Other (specify			23d. Date Mont	of delivery th Day Year			
ords, P.	The law requires that the site has been signed by the bage 2 should be detached.	by	Part II. Other significant conditions con	tributing to death but no	ot resulting in th	e underlying cause	given in Part I.			oute to the cause of death?			
al Records,		Completed						24a. Was a autops perforr 1 🗆 Yes 2	y pri ned? de	ere autopsy findings available for to completion of cause of sath? Yes 2 \(\text{No} \)			
Division of Vital	F F E	ition: To Be	25. Was case referred to medical examiner? 1 Yes 2 No H 27. Manner of Death 1 Natural 5 Pending investigation	ospital: 1 🗹 Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpa 28b. Time Injur	e of 28c. h	Othor	eath (Check only on Home 5 Reside 28d. Describe ho	ence 6 Other				
Divis	To the Hospital or Attending within 24 hours after death. To the Funeral Diractor: After completely filled in by the fune.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm,	street, factory, offi	сө	28f. Location (St. City or Town	reet and Number n, State)	r or Rural Route Number,			
	To the Hospital within 24 hours a To the Funeral C completely filled	edicai	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	sician: To the best of morer: On the basis of exa and manner stated.	y knowledge, de umination and/o	eath occurred at the r investigation, in m	e time, date and pla ny opinion, death oc	ce, and due to the ca curred at the time, da	ause(s) and manr ate and place, an	ner as stated. Indicate to the cause(s)			
	Som Som	Σ	29b. Signature and little of certifier	8 MD		D	4652			(Month, Day, Year) 3 2008			
1	Sta Registra	-	30. Name and address of person who con State (Month, Day, Year) MAR 1 8 2008	mpleted cause of death	25A+	Print) Prover	AFKUA	1 GREG	4BELI N	Offoc analyana			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 11, 2008 Viergela Baptiste 1:10p M March 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Sligo Creek Nursing Home Montgomery Takoma Park 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Months Days Hours 1 M 2 F 92 579-04-8870 12/15/1915 Haiti Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Prince George' 1 ☐ Yes 2 No Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5210 56th Avenue 20871 Haiti 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛂 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Tes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Black 3 AWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Manuel Solomon Coneele Solomon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Gedeon/Daughter 5518 Kennedy Street Riverdale, Md. 20737 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven 3/15/2008 Silver Spring, Md 4 Donation 5 Dother (Specify) 21. Signatur 1 Juneral Service Liven ee P部门即 Mr. RYNALDI FUNERAL SERVICE P.A. Mell 9241 Columbia Blvd.Silver Spring,Md 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final a Atherosclerotic cardiovascular disease disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Year Day 4 ☐ Pregnant at time of death 5 Other (specify) 9☐Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2X No 3 Probably 4 Unknown 24a. Was an

Physician /Medical Examiner

certificate be executed

Box 68760

Division or Vital Records, P.O.

Hospital or Attending

the Funeral Director: A

To the l within 2

Medical

Physician

/Medical

Examiner

Director

Funeral

ģ

Completed

Be

ပ

MD

Funeral

Director

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

burial-tran physician the i attending nse ρ the à peen certificate has page 2 this

Examiner Physician/Medical þ Completed Be 2 After t Certification:

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

autopsy

performed? Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death

1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 ☐ Suicide

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 41 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier

Mn

D0060100

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tahmina Ahmed M.D. 831 University Blvd. East Silver Spring, Md 20912

State Registrar

31. Date filed (Month, Day, Year)

MAR 1 8 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien

		Registrar 1. Decedent's Name (First, Middle, La			ficate of	Deam	2. Date of De	Reg. No eath Da		3. Time of Dea
hysicia /Medica xamine	ıl 🦡	4a. Facility Name (If not institution, giv	· · · · · · · · · · · · · · · · · · ·		4b. City, Town, o	r Location of Deat	March	16,		11:27
neral ector		5. Social Security Number 6. S 578 – 28 – 7721 Usual Residence of Decedent	MM alle		If Under 1 Year Months Days	If Under 24 Hrs Hours Min		rth ay, Year)		hplace (State or Fo buntry) hington,
tiffed at	ctor	10a. State 10b. County Maryland	10c. City	y, Town or Loca Baltim						10d. Inside City L 1 ☐ Yes 2[
nust be no	Funeral Director	10e. Street and Number 737 Stoney Spring	Drive	S 12 Wa		210	Specify Vos or N	Uni	ited Sta 14. Race - Ame	tes
Examiner	≥	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates:		es, specify Cub	lispanic Origin? (9 an, Mexican, Puer <i>Sp</i> ec <i>ify:</i>	rto Rican, etc.)		Black, White	e, etc.
he Medical	Completed	15. Decedent's E (Specify only highest gra- Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Give kir life. DC	nt's Usual Occup nd of work done NOT use retired alesman	ation during most of wo d)	orking		aind of Business/ Automobi	,
raumatic event, ti	O Be Co	17. Father's Name (First, Middle, Last	Israel Bachrac		a resilian		me (First, Middle	, Maider		163
her trauma		19a. Informant's Name/Relationship (Burt Bachrach, Sc	n	737 St	oney Sp	and Number or Fi ring Dri	ve, Balt	imor	re, MD	21210
imporent; it rent 21 is marked ones than traduct, or testis 238 or zeast show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Septice Lice)	y) Kin	g David		e) 03/ al Garde ss of Facility Hebrew		Fal	ocation - City or	,
ic journal and as the burial-transit as the burial-transit as the burial-transit as the burial transit as the	edical Examiner	23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	plications that caused the death one cause on each line. Congestive a. Due to (or as a consequence) Custo (or as a consequence) Due to (or as a consequence) Custo (or as a consequence) Due to (or as a consequence)	Heart F uence of): Ire	the mode of dyir	1 St., N	W	arrest,	JII, UC	20012 Approximate Interval Betwee Onset and Dea 6 Month
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit										
ched for use as the	-	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	Ideath 3 □E	ctopic pregnancy Other <i>(specify)</i>	′			23d. Date of del Month	ivery Day Yea
ould be detached for use as the	by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 □Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	Ideath 3□Edeath 5□C	Other (specify)				Month use contribute to	,
incare has been signed by the avending princare has been signed by the avending princare has been sometimed for use as the	Completed by Physician/M	23b, Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant conditions of	1 □Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	Ideath 3□Edeath 5□C	Other (specify)	en in Part I.	1 □ 24a. Was auto perf 1□ Yes	Yes 2 san spsy ormed? 2 No	Month use contribute to	Day Yea
by the funeral director, page 2 should be detached for use	lo Be Completed by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown contributing to death but not result Hospital: 1 Inpatient 2 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	Other (specify) arriving cause giv 3 DOA Oth 28c. Injur Wor M 1	en in Part I. 26. Place of De er: 4 \(\) Nursing I	1 □ 24a. Was auto perf 1□ Yes ath (Check only) Home 5 🂢 Res 28d. Describe	Yes 2 an psy ormed? 2 1 No one) idence how inju	Month use contribute to No 3 Pr 24b. Were au prior to death? 1 Yes 6 Other (Special Control of the Control	Day Yea the cause of deat tobably 4 □ Unk utopsy findings ava completion of caus
by the funeral director, page 2 should be detached for use	edical Certification: To be Completed by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of the conditions of	Hospital: 1 Inpatient 2 At hospital: 2 Date of Injury (Month, Day Year) 28e. Place of Injury - At ho	ER/Outpatient 28b. Time of Injury whedge, death o	all DOA Other (specify) 3 DOA Other Wor M 1 the transfer of t	en in Part I. 26. Place of De er: 4 Nursing I y at k? Yes 2 No	24a. Was auto perfiling yes with (Check only Home 5 🂢 Res 28d. Describe 28f. Location (City or To	Yes 2 an psy primed? 2 No one) idence how inju (Street ar wn, State e cause(s, date an	Month use contribute to No 3 Pr 24b. Were au prior to death? 1 Yes 6 Other (Special of Number or Rule) and Number or Rule) 3) and manner as diplace, and due	Day Yea the cause of deat robably 4 □Unk thopsy findings ava completion of caus 2 □ No cify) ural Route Number s stated. to the cause(s)
led in by the funeral director, page 2 should be detached for use	edical Certification: To be Completed by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of the conditions	Hospital: 1 Inpatient 2 Hospital: 1 Inpatient 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	ER/Outpatient 28b. Time of Injury wledge, death o tion and/or investigations.	accurred at the tistigation, in my countries by 16	en in Part I. 26. Place of De er: 4 Nursing I yat k? Yes 2 No me, date and place opinion, death occurrence or commender.	24a. Was auto perfiling yes with (Check only Home 5 🂢 Res 28d. Describe 28f. Location (City or To	Yes 2 s an spsy ormed? 2 Noone) sidence how inju	Month use contribute to No 3 Pr 24b. Were au prior to death? 1 Yes 6 Other (Spectry occurred	Day Yea o the cause of deat robably 4 □ Unk utopsy findings ava completion of caus 2 □ No cify) ural Route Number s stated. to the cause(s) h, Day, Year)

DHMH 17 Rev 1/2001

Jew 10

State Registrar

DHMH 17 Rev 1/2001

Kenneth L 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

110 Hospital Road . HIGHOH 32. Registras Signature MAR 19 2D08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print),

29c. License number

1) 56024

Saile 110

29d. Date signed (Month, Day, Year) March 17 2008

Prince Frederice MI) 20678

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hydiege

, ,	0.07
State of Maryland	Department of Health and Mental Hygiene 🛭 🗍

			te of Maryland	d / Depa		Health and M	Mental Hygi		10498
		Decedent's Name (First, Middle, Last)					2. Date of Death Month	n Day Year	3. Time of Death
Physic		Margaret Birch	Bradfor	ď			March	15, 2008	10:00 a ^M
/Medi Exami		4a. Fecility Name (ff not institution, give street a	and number)		4b. City, Town,	or Location of Death	1	4c. County of Dea	th
Exam		722 S. Schumaker Dr:	ive		Salis	bury		Wicom	ico
Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2	7. Age (In yrs. la	est birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, 5/29/19		thplace (State or Foreign buntry) Maryland
۵ ,		Usual Residence of Decedent 10a. State 10b. County	10c City	, Town or Lo	ocation				10d. Inside City Limits
aryla shov	-	Maryland Wicomico		lisbu					1 √ Yes 2 □ No
he M	Director	10e. Street and Number		TIBDU.	10f. Zip Code		10	ng. Citizen of What C	ountry?
with t		722 S. Schumaker Dr	ivo		2180	Λ		USA	,
eath	Funeral		s Decedent Ever in U.S	S. 13.			pecify Yes or No-	14. Race - Am	encan Indian,
ter d	'n.	1 Never Married 2 Married 1	ned Forces? TYes 2.√TNo	1		Hispanic Origin? (S ban, Mexican, Puert	o Rican, etc.)	Black, Whi	te, etc.
urs al	þ	If Y	es, Give ar or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify: W	hite
IL LISTONOSO filed within 72 hours after death with the Maryland Hygiene than "natural", or Items 23e or 28e-f show ant, the Medical Evanirat must be notified at	Completed	15. Decedent's Education (Specify only highest grade comp	nleted)	16a. Dece	dent's Usual Occu	upation a during most of wor		16b. Kind of Business	/Industry
thin 7	npie		llege (1-4or 5+)			e during most of wor ed)			
Maryiarid < 1.2.13-0030 d 2 should be filed within 72 hours alf th and Mental Hygiene. 77 is marked othar than "natural", or treaumatic event, the Medical Event traumatic event.	ခြ	12	- 17	cash	ier	40 44-15-1-1-1-1	/Finch Adiabath. A	Holloway	Store
tal Hydrad doth	Be	17. Father's Name (First, Middle, Last)					ne (First, Middle, M Bradford		
aryia should I and Men marke	ုင္	Calvin Birch							Zin Codol
2 sh 2 sh 1 and 1 s m		19a. Informant's Name/Relationship (Type, Pri Bille Jo White/daught						City or Town, State,	
NOTE, INITIVIATION ZIZIONOSO 1985 1 and 2 should be filed within 72 hours after death with the Marylan 10 of Health and Mental Hygiene 11 filam 27 is marked other than "natural", or Items 23e or 28e-f show 12 other traumatic event, the Medical Examinat must be notified at		20a. Method of Disposition						20c. Location - City or	
SALLIMOTE, oermit. Pages 1 ar Department of Hea importent: if itam: any injury or other once.		1 ☐ Burial 2 X Cremation 3 ☐ Remova	ii from State		osition (Name of matory or other pl	'			
ILITY I. Pa It her Ither Ither Injury	-	` 4 □Donation 5 □ Other (Specify)	Sa			tory 3/19		Salisbury	
Dalltimore, permit. Pages 1 and Department of Heall Importent: If item 2 and injury or other once.		1000	OF CESE		Holloway	Funeral	Home Prof	essional . ry, MD 21	Association
		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau							Approximate
	8 0	shock, or heart failure. List only one cau Immediate Cause (Final	se on each line.	D					Interval Between Onset and Death
Physician /Medical	-	disease or condition resulting in death) a.	(01	17.00					
Examiner			Due to (or as a consequ	- PW	2 A				
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or is a consequ	nce of):	100				
uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c	HM						
be executed icien and burial-transit			Due to (or as a consequ	ience of	0010	1			
te be e ysicien ne buria	cai	d	Lun	100	enon	<u> </u>			
ob rtifical ng phy as th	Jed	IF FEMALE:		1					
BOX eath cert attending for use	an/	23b. Was decedent pregnant	res, outcome of pregna □Live birth 2 □Fetal	death 3	⊒Ectopic pregnan			23d. Date of de Month	Day Year
the dea y the at	sici	1 Van 2 1 Na	∃Pregnant at time of de ∃Unknown	eath 5	Other (specify)				
, P.O. BOX 08/00, that the death certificate be executed ted by the attending physicien and detached for use as the burial-transit	by Physician/Medi	Part II. Other significant conditions contributi	ng to death but not resu	ulting in the u	underlying cause of	oven in Part I.	23e. Did tot	pacco use contribute	to the cause of death?
DIVISION OT VITAI HECOTOS, P., tor Attanding Physician: The law requires that! after death. Director: After this certificate has been signed by in by the funeral director, page 2 should be detail in by the funeral director, page 2 should be detail.	þ	r arm. Other signmount contains a	ng to toall but not root	g			1 □ Ye	s 2 □ No 3 □ F	robably 4 Unknown
w requir	etec						24a. Was a	n 24b Were a	utopsy findings available
Hec e law has l	Completed						autops	ned? prior to	completion of cause of
n: Th						OC Place of Do	1 ☐ Yes ath (Check only on	2 No 1 Ye	s 2 No
VIII sicial certifirecto	Be C	25. Was case refer/ed to medical examiner? 1 Yes 2 No Hospita	al: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3□ DOA)thos:	/	ence 6 Other (Sp	ecify)
Phys r this	7: To		. Date of Injury	28b. Time	of 28c. In	ury at	,	ow injury occurred	,
On ding	tion	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		lork? ∐Yes 2. □No			
Attar r dea ector by the	ifica	0.000	a. Place of Injury - At he	me, farm, si	treet, factory, offic	е	28f. Location (St City or Town	reet and Number or F	Rural Route Number,
Blor A safter safter all Director addings	Certification:	* [] Hornicide	building, etc. (Specify	''		1	2., 3		
UNISION OF VITAL RECORDS, P.O. BOX 08/ To the Hospital or Attanding Physician: The law requires that the death certificate within 24 hours after death. To the Funaral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	edical ((Check only 2 Modical Exeminer: C	To the best of my kno in the basis of examinat manner stated.	wledge, dea tion and/or in	th occurred at the nvestigation, in my	time, date and place opinion, death occu	e, and due to the carred at the time, d	ause(s) and manner a ate and place, and du	as stated. se to the cause(s)
To the within 2 To tha complet	Me	29b. Signature and title of certifier)		29c. Lice	nse number	2	9d. Date signed (Mor	nth, Day, Year)
(_ A		1x Can all	Come I	~ 7	De	06095	8	3/17/0	8
784		30. Name and address of person who complet	ed cause of death (Item	1 23a) (Type		,			541 mg
- •		2	, Mccl 3	1575		e plac	e to	1	21801
S	tate	31. Date filed (Month, Day, Year) MAR 19 2008	32. Fogistrar's Signa	ture	beceto 1	,			
Regis	trar	MINK I A KONO	MERCE .	For A	and the second				

			1 - For State of Maryland / Depa	artment of Health and Natificate of Death	Mental Hygier	2111118 11118 3 3
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month March 14,	3. Time of Death
A STATE OF	/Medic	cal	Edward T. Borawski	4b. City, Town, or Location of Death	1	2008 12:30 p ^M 4c. County of Death
1	Examin	ier	4a. Fecility Name (If not institution, give street and number) Fort Washington Hospital	Fort Washington		Prince George
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	
	Director		269–12–9434 X M 2□F 87 Yrs.	Months Days Hours Min.	July 3,19	
	land bw		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo	cation		10d. Inside City Limits
	Mary Iled	to	Maryland Charles Indian He	ead		1 ☐ Yes 21⁄2 No
	th the	lrec	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Country?
	ath wil	rai	3205 Wright Road	20640		.S.A.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 ie marked other than "natural", or items 23a or 28a-f ehow any injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral Director	1 Never Married 2 TVM Arried 1 TVYYes 2 □ No	Was Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto I ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
5	72 ho natur	Completed	15. Decedent's Education 16a. Deceder (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work	ring 16b.	Kind of Business/Industry
121	within one. than	mp	Elementary/Secondary (0-12) College (1-4or 5+)	OO NOTuse retired) strial Hygienist	II	.S. Government
	filed Hygie other	CC	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid	
<u>la</u> n	Aental Aental rked ticev	To Be	Charles Borawski	Rose I	Flaczynski	
Maryland	2 sho and h le ma auma			ng Address (Street and Number or Run		
-	t and lealth om 27		20h Place of Disposition	Wright Rd., India		d. 20640 Location - City or Town, State
Baltimore	t. Pages 1 tment of h rtant: If ite		1 XBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Maryland	natory or other place) March 2 Veterans Cemetery	25, 2008	heltenham, Maryland
Ba	permi Depen Impor			Name and Address of Facility Illiams Funeral Ho		W 3 W3 20040
			23a. Part1. Enter the disease, or complications that cased the death. Do not ent shock, or feart failure. List only one cause on each line.	4270 Hawthorne Rd. er the mode of dying, such as cardiac		Head, Md. 20640 Approximate Interval Between
d sale	Physician		Immediate Cause (Final disease or condition	. 0		onset and Death
1	/Medical Examiner		resulting in death) Due to (or as a consequence of):) / 6		
	Cxammer	-	Sequentially list conditions, if any, leading to immediate b. Que to (or as a consequence of)	aller		days
	uted	Examiner	cause. Enter Underlying Cause (Disease or injury	larillation	ر م	days
oʻ	exection and and rial-tra		that initiated events resulting in death) Last Due to (or as a consequence of):	Of the second		U'
8760,	Attending Physicien: The law requires that the death certificate be executed rideath. actor: Atter this certificate hes been signed by the ettending physicien and by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	d			
Ó	entifica ding pt	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy			20101111
Вох	es that the death certific igned by the ettending p be detached for use as	cian	in the past 12 months?	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
P.O.	the d	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown			
œ.	s that	by PI	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
ğ	w require been sign should b	ted			1 Tes	2 No 3 Probably
ecc	e law r hes be	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
四田	ding Physicien: The h. h. After this certificate he funeral director, page				performed 1☐ Yes	
ij	sicient certif irecto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	Other	h (Check only one)	6 ☐Other (Specify)
o	g Phy er this	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of		28d. Describe how in	
ion	auth. oath. or: Aft	atio	2 Accident investigation	M 1 Yes 2 No		
Division of Vital Records,	i di di	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, strubulding, etc. (Specily)	eet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	To the Hospitel or Attent within 24 hours after deating the Funerel Director: completely filled in by the	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death and manner: On the basis of examination and/or invariant manner stated.	restigation, in my opinion, death occur	red at the time, date a	and place, and due to the cause(s)
	To the To the comple	2	29b. Signature and title of certifier A. T. Etablacu My	29c. License number 5 +604		Date signed (Month, Day, Year)
a	Bill		30. Name and address of person who completed cause of death (Item 23a) (Type,	Fort wa	shington,	Maryland 20744
	Sta	te	Amir Mirza-Alikhani, M.D., Fort WAshi 31. Date filed (Month, Day, Year) 32. Registrar's Signature	ngton Hospital, 1	ı/ıı LlVlr	igston ka.,
	Registr	-	MAP 1 9 2008 Research	40		
DH	MH 17 Rev 1/20	001	MAR 1 9 2008 Seem & Speed	W		

ORIGINAL

DHMH 17 Rev 1/2001

			For State Registrar	State	of Maryla	nd / Depa	artmen rtificate					giene Reg. No	2008	10500	
	Physicia	an	Decedent's Name (First, Middle								2. Date of De Month	Day	Year	3. Time of Death	
	/Medic	al	Agnes Virg		Betts		4h City	Town or	Location of		March	16,	2008 County of Death	4:58P M	_
F	Examin	er	1110 Clark Av		uniber)			aldo		or Death		10.	Char]		
	Funeral		5. Social Security Number	6. Sex	7. Age (In yr	s. last birthday)		1 Year Days		24 Hrs.	8. Date of Bir (Month, Da	th av. Year)	0 Rieth	hplace (State or Foreign	
и	Director		216-22-3569	1 □ M 2 🖾 F	91	Yrs.	IVIOTILIS	Days	riodio	F	ebruary	721,1	917 Mar	yland	_
	land		Usual Residence of Decedent 10a. State 10b. County		10c. (City, Town or Lo	ocation							10d. Inside City Limits	-
	Mary Fied a	tor	Maryland Charl	Les		Waldori	E							1 □Yes 2 XNo	
	th the	Director	10e. Street and Number				10f. Zip					-	en of What Co		
	ath w	ral	1110 Clark Avenu					2060					ted Sta		_
	items items iner m	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marri	Armed F	cedent Ever in forces? 2 137No				spanic Ori n, Mexicar	gin? (Spe n, Puerto	ecify Yes or No Rican, etc.))- 1	4. Race - Amer Black, White	e, etc.	
5-003b	urs af	þ	3 Widowed 4 Divorced	If Yes, G Year or I	iive		1 ☐ Yes	2∰ No	Specify:				Specify: Wh	ite	
ָ בַּ	e filed within 72 hours after death with the Maryland of Hygiene. of Hygiene. of Hygiene. vent, the Medical Exteniner must be notified at	Completed	15. Decedent (Specify only highes)	16a. Dece	dent's Usua kind of wor DO NOT us	al Occupa	ation Juring mos	t of worki	na		nd of Business/I	,	
7	vithin the. than " e Mer	фш	Elementary/Secondary (0-12)		(1-4or 5+)		<i>DO NOT us</i> e ter ia					1	les Cou	nty lucation	
2	filed v Hygie offher i		12 17. Father's Name (<i>First, Middle,</i>	 Last)		Care	sterre	a Mai	-		(First, Middle			deation	-
=	lid be i lental i rked o iic eve	To Be	John Francis Mu	irphy					Addi	e Gr	igsby N	lurph	У		
چ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Exeminer must be notified at once.	_	19a. Informant's Name/Relations	nip (Type. Print)		19b. Maili	ng Address	(Street a	and Numbe	er or Rura	Il Route Numb	er, City or	Town, State, Z	Zip Code)	
√. Σ	and 2 lealth m 27 i		Norma Clark/Daug	ghter	loo		188 E								_
0	Pages 1 nent of H nt: If Ite iry or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation		State	. Place of Dispo cemetery, cre		_			ate		cation - City or		
aitimoi	iit. Pa artmer ortant injury		4 □ Donation 5 □ Other (S		Ţr:	inity Me					20,200			Maryland	_
g	Dep Impo		21. Signature of Eurogal Service Licenses M01458 22. Name and Address of Facility AREHART-ECHOLS FUNERAL HOME, P.A. 21. Signature of Eurogal Service Licenses M01458 22. Name and Address of Facility AREHART-ECHOLS FUNERAL HOME, P.A. 21. Signature of Eurogal Service Licenses M01458										5 1. 6		
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that	caused the de	eath. Do not en	ter the mod	e of dying	g, such as	cardiac c	or respiratory a	rrest,		Approximate Interval Between	
y i	Physician		Immediate Cause (Final disease or condition	Ar	VAN	icr.D.	Hi	725	(-Vi	03G	LER	IRA	3	Onset and Death	(
7	/Medical Examiner		resulting in death)	Due to	(or as a cons		220	1 1	00	0.0	LER	n	. 0 -	0	-
		er	Sequentially list conditions, if any, leading to immediate	b. Due to	O (or as a conse	equence of):	0 77	ں ہی	012	10/2	20 V H	CZCN	CHIS	Brosen .	-
	d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		J										
Ď,	an an	Еха	resulting in death) Last	Due to	(or as a conse	equence of):									-
9/90	sate be executed shysician and the burial-transit	lical		d										· · · · · · · · · · · · · · · · · · ·	_
×	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Med	IF FEMALE:	23c. If yes, o	utcome pf preg	inancy							2d Date of deli	luon.	
POX	death e atten	ician	23b. Was decedent pregnant in the past 12 months? 1□Yes 📜 No	1 ☐ Live	birth 2□Fe nant at time o	etal death 3	⊒Ectopic pr ⊒ Other <i>(</i> s <i>p</i>						3d. Date of deli Month	Day Year	
	t the c by the	hysi	9 Unknown	9□Unk	nown										_
S,	requires that the een signed by th nould be detache	by P	Part II. Other significant condition	ns contributing to	death but not re	esulting in the u	nderlying c	ause give	en in Part I.					the cause of death?	
cords,	een si										1 1	Yes 2	XNo 3∏ Pro	obably 4 Unknown	_
6.3	e law has b	Completed					-				24a. Was		24b. Were au prior to death?	topsy findings available completion of cause of	
<u></u>	n: Th ficate r, pag		OF 18/ annu referred to modical								1□ Yes	2 🔀 No	1 ☐ Yes	2 No	_
VItal	s certi	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ XNo	Hospital:] Inpatient 2	☐ ER/Outpatier	nt 3 🗆 DC	Othe	or.		Check only		□Other (Spec	Diff()	-
0	ig Phy ter this neral o	n: To	27. Manner of Death	28a. Date	e of Injury nth, Day Year)	28b. Time o		28c. Injury Work			28d. Describe				
SION	endin sath. or: Af he fur	atio	1 Natural 5 Pending 2 Accident investig	jation	mm, buy rour,	,,	М		Yes 2□	No					
Š	or Att	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined Zee. Plac	e of injury - At ding, etc. (Spe	home, farm, str cify)	reet, factory	, office		2	28f. Location (City or To			ıral Route Number,	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical C	29a. Certifier (Check only one) Certifyin Certifyin Medical	g Physician: To the Examiner: On the and ma	ne best of my k basis of exami nner stated.	nowledge, deat ination and/or in	h occurred ivestigation	at the tim	ne, date ar pinion, dea	nd place, a ath occurr	and due to the ed at the time	cause(s) , date and	and manner as place, and due	s stated. e to the cause(s)	-
	To the complete th	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)													
Ì			JA 11	Low	han '	VVV		7	16) 6	9	\-	5/17	100	_
1	BID		30. Name and address of person	WHO completed cal	use of death (It	em 23a) (Type,	Yint)	NF	TU	00	RY-,	W	Q.	20603	_
	Sta Registr		31. Date filed (Month, Day, Year)	-1	Pogistrar's Sig	nature	barte	,						•	